

1. FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

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VS. A15ME SM 9/60

02196 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Leon (Unknown) Allen</u>				4. DATE OF DEATH <u>February 27, 1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 18, 1875</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardner (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Truck Gardner</u>		11. BIRTHPLACE (State or foreign country) <u>Prince Geo. Cty., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Isaiah Allen</u>				14. MOTHER'S MAIDEN NAME <u>Laura Margaret Pyles</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mrs. Zora M. Corley, Upper Marlboro, Md.</u>				Address <u>RFD Box 4424,</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u>							
DUE TO (b) <u>Cardiovascular renal disease</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Mar. 3-62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Bells Methodist Cem.</u>				22d. LOCATION (City, town, or country) <u>Camp Springs Md</u>			
23. FUNERAL DIRECTOR <u>Samuel Bros</u>				24a. REC'D BY REGISTRAR <u>1661- Good Hope Rd SE</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hanna</u>			
				DATE <u>MAR 2 '62</u>			

(5150)

1. The first part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

coroner notified and approved B.K.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02197					02180						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <b>Prince George's</b> MARYLAND					b. STATE <b>Maryland</b> c. COUNTY <b>Prince George's</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>						
c. LENGTH OF STAY IN 1b <b>3 days</b>					d. STREET ADDRESS <b>4618 Burlington Road</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
			<b>Mary Richardson Ashbrook</b>			<b>February 20</b>			<b>19 62</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-30-84</b>		9. AGE (In years last birthday) <b>77 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Illinois</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Edward Richardson</b>					14. MOTHER'S MAIDEN NAME <b>Mary Schackmann</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>					16. SOCIAL SECURITY NO. <b>579-44-1536B</b>					17. INFORMANT <b>Grover H. Ashbrook Same as #2 (Husband)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Myocardial Infarction, Anterior</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery thrombosis</b> DUE TO (c) <b>" " atherosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)
21. I certify that (I) (this hospital) attended the deceased from <b>2-17</b> to <b>2-20</b> , 19 <b>62</b> ; that (I) (we) last saw the deceased alive on <b>2-20</b> , 19 <b>62</b> , and that death occurred at <b>8:40</b> A.M., from the causes and on the date stated above.											
22a. SIGNATURE <b>Donald C. Edgren</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>2-20-62</b>			
22c. PHYSICIAN'S NAME (Type) <b>DONALD C. EDGREN</b>					22d. ADDRESS <b>HYATTSVILLE, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county)			(State)
<b>Entombment</b>			<b>2/23/62</b>		<b>Cedar Hill</b>			<b>Suitland,</b>			<b>Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Gasch's Sons</b>					ADDRESS <b>Hyattsville, Maryland</b>			25a. REC'D BY REGISTRAR DATE <b>FEB 23 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02198

02181

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>D.C.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland 23</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington DC</b>			
c. LENGTH OF STAY IN 1b <b>5mo-7days</b>				d. STREET ADDRESS <b>1609-30th St. S.E.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suitland Nursing Home, Inc.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MALVINA</b> Middle Last <b>BACHE</b>				4. DATE OF DEATH Month <b>February</b> Day <b>6</b> Year <b>1962</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/17/77</b>	9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laboratory Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.America</b>	
13. FATHER'S NAME <b>William Russell</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Watts Burton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>5-5450-6662</b>		17. INFORMANT Address <b>Mrs Nora Seidler (daughter) as above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> DUE TO <b>Congestive Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardiac disease</b> DUE TO <b>unknown</b> (c) <b>arteriosclerosis</b> DUE TO <b>unknown</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1</b> 19 <b>62</b> to <b>Feb 6</b> 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>Feb 3</b> 19 <b>62</b> , and that death occurred at <b>8 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>H G Hadley</b>				22b. ADDRESS <b>4601--Nichols Ave S.W. Wash. DC</b>			
22c. PHYSICIAN'S NAME (Type) <b>Henry G. Hadley</b>				22d. ADDRESS <b>4601--Nichols Ave S.W. Wash. DC</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 7-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Inglewood Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Inglewood - Calif.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ammons Bros.</b>				25a. REC'D BY REGISTRAR <b>1661- Good Hope Rd SE</b>		25b. REGISTRAR'S SIGNATURE <b>Clarence S. Thayer</b>	
				DATE <b>FEB 8 '62</b>			

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VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
02199						CERTIFICATE OF DEATH			02182		
Items 2 & 14 Film G507 2/26/62 iwk											
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> <b>Penna</b> b. COUNTY <b>PRINCE GEORGES</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>				c. LENGTH OF STAY IN 1b <b>4 HRS 25 MIN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> <b>Pittsburg 75X3</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US AIR FORCE HOSPITAL</b>						d. STREET ADDRESS <b>1406 N. Homewood Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>BANNER</b> Last <b>BANNER</b>						4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>21</b> Year <b>1962</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10 JUNE 1931</b>		9. AGE (In years last birthday) <b>30</b> yrs.		10. IF UNDER 1 YEAR Months <b>30</b> Days <b>30</b> Hours <b>30</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AIRMAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>US AIR FORCE</b>		11. BIRTHPLACE (State or foreign country) <b>PITTSBURGH, PENNSYLVANIA</b>				12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>OLIVER BANNER</b>						14. MOTHER'S MAIDEN NAME <b>LUCILLE unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>1952 -PRESENT 194-22-4744</b>		17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse</b> <b>971.6</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fatty necrosis of heart, kidneys, liver</b> (c) <b>Phosphorus poisoning</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Suicide due to depressive reaction.</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>SUICIDE Ingestion of commercial preparation of rat poison.</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>Unk.</b> p.m. <b>20-21 Feb 62</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Barracks</b>		20f. (City or town) (County) <b>AAFB, -Pr. Geo. 25 D.C.</b>			
21. I certify that (I) (the hospital) attended the deceased from <b>21 FEBRUARY 1962</b> , to <b>21 FEBRUARY 1962</b> , that (I) (we) lost the deceased alive on <b>21 FEBRUARY 62</b> , and that death occurred at <b>610A</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>William K Grove Capt USAF MC</b> M.D.						22b. ADDRESS <b>USAF Hospital, Andrews Air Force Base, Md</b>		22c. PHYSICIAN'S NAME (Type) <b>WILLIAM K GROVE, Capt USAF MC</b>		22d. DATE SIGNED <b>21 FEB 62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>23 FEB 62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PITTSBURGH PENNA.</b>				23d. LOCATION (City, town, or county) (State) <b>PITTSBURGH PENNA.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>B. H. Taylor</b>						25a. REC'D BY REGISTRAR <b>FEB 23 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hance</b>			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
SM 9/60

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>02200</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div> <div>02183</div> </div> </div> <div> <div> <div> <div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> </div> <div> <div> <div>Prince George's</div> <div>MARYLAND</div> </div> </div> </div> <div> <div> <div>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</div> <div>a. STATE</div> <div>b. COUNTY</div> </div> <div> <div> <div>Maryland</div> <div>Prince George's</div> </div> </div> </div> </div>															
<div> <div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>c. LENGTH OF STAY IN 1b</div> </div> <div> <div>Cheverly</div> <div>D.O.A.</div> </div>				<div> <div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>d. STREET ADDRESS</div> </div> <div> <div>Bowie</div> <div>Fletcherstown Road</div> </div>				<div> <div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div>							
<div> <div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</div> </div> <div> <div>Prince George's General Hospital</div> </div>				<div> <div>4. DATE OF DEATH</div> <div>Month</div> <div>Day</div> <div>Year</div> </div> <div> <div>February</div> <div>9th</div> <div>1962</div> </div>											
<div> <div>3. NAME OF DECEASED (Type or print)</div> </div> <div> <div>Ernest</div> <div>Martin</div> <div>Barrios</div> </div>				<div> <div>5. SEX</div> <div>6. COLOR OR RACE</div> </div> <div> <div>Male</div> <div>Colored</div> </div>				<div> <div>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/></div> <div>8. DATE OF BIRTH</div> </div> <div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div> <div>November 12/85</div> </div>							
<div> <div>9. AGE (In years last birthday)</div> <div>IF UNDER 1 YEAR</div> <div>Months</div> <div>Days</div> <div>Hours</div> <div>Min.</div> </div> <div> <div>76</div> </div>				<div> <div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>10b. KIND OF BUSINESS OR INDUSTRY</div> </div> <div> <div>Laborer</div> <div>Retired</div> </div>				<div> <div>11. BIRTHPLACE (State or foreign country)</div> <div>12. CITIZEN OF WHAT COUNTRY?</div> </div> <div> <div>Florida</div> <div>U. S. A</div> </div>							
<div> <div>13. FATHER'S NAME</div> </div> <div> <div>Emanuel Barrios</div> </div>				<div> <div>14. MOTHER'S MAIDEN NAME</div> </div> <div> <div>Elyabeth Carter</div> </div>											
<div> <div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)</div> </div> <div> <div>Yes</div> <div>WWI</div> </div>				<div> <div>16. SOCIAL SECURITY NO.</div> </div> <div> <div>203-22-848</div> </div>				<div> <div>17. INFORMANT</div> <div>Address</div> </div> <div> <div>Mrs. Carrie Fletcher, same as #2</div> </div>							
<div> <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> </div> <div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>442X</div> <div>Acute Congestive heart failure</div> <div>Cardiovascular renal disease</div> <div>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b)</div> <div>CAUSE LAST, (c)</div> </div>												<div> <div>INTERVAL BETWEEN ONSET AND DEATH</div> </div>			
<div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div> </div>												<div> <div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div>			
<div> <div>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</div> </div>				<div> <div>20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)</div> </div>											
<div> <div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>Hour a.m.</div> <div>p.m.</div> </div> <div> <div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div> </div> <div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> </div> <div> <div>20f. (City or town)</div> <div>(County)</div> <div>(State)</div> </div>															
<div> <div>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div> </div>															
<div> <div>ACTUAL SIGNATURE</div> </div> <div> <div>James I. Boyd</div> </div>				<div> <div>CHIEF MEDICAL EXAMINER <input type="checkbox"/></div> <div>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></div> <div>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></div> </div>				<div> <div>DATE SIGNED</div> </div> <div> <div>2/9/62</div> </div>							
<div> <div>EXAMINER'S NAME (Type)</div> </div> <div> <div>JAMES I. BOYD, M.D.</div> </div>				<div> <div>Address (Street, city, town, or county)</div> </div>											
<div> <div>22a. BURIAL, CREMATION, REMOVAL (Specify)</div> </div> <div> <div>BURIAL</div> </div>				<div> <div>22b. DATE THEREOF</div> </div> <div> <div>2.13.62</div> </div>				<div> <div>22c. NAME OF CEMETERY OR CREMATORY</div> </div> <div> <div>ARLINGTON NAT'L. CEM.</div> </div>				<div> <div>22d. LOCATION (City, town, or country)</div> <div>(State)</div> </div> <div> <div>ARLINGTON, VIRGINIA</div> </div>			
<div> <div>23. FUNERAL DIRECTOR</div> <div>ADDRESS</div> </div> <div> <div>1820 9TH ST., N.W.</div> <div>WASHINGTON, D.C.</div> </div>				<div> <div>24a. REC'D BY REGISTRAR</div> <div>DATE</div> </div> <div> <div>FEB 13 '62</div> </div>				<div> <div>24b. REGISTRAR'S SIGNATURE</div> </div> <div> <div>Arthur S. House</div> </div>							

MEDICAL CERTIFICATION

08150

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(M)

UNITED STATES DEPARTMENT OF THE INTERIOR

WASHINGTON, D.C.

02201

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover Hills</u>				c. LENGTH OF STAY IN 1b <u>1 1/2 yr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4109 Beall Street</u>				d. STREET ADDRESS <u>—</u>			
3. NAME OF DECEASED (Type or print) First <u>BLANCHE</u> Middle <u>IRENE</u> Last <u>BENNETT</u>				4. DATE OF DEATH Month <u>2</u> Day <u>6</u> Year <u>1962</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 26 1880</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H-wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Leonardtown, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Bushrod Nash</u>				14. MOTHER'S MAIDEN NAME <u>Maria Elizabeth Dyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>R. M. Bennett - 6003 Wilmet Rd Bethesda 14 Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Bladder</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6/15</u> , 19 <u>61</u> , to <u>2/6</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>2/4</u> , 19 <u>62</u> , and that death occurred at <u>6:10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4410 74th Ave Wash D.C.</u> DATE SIGNED <u>2/6/62</u>							
ACTUAL SIGNATURE <u>F. E. Muser</u> M.D.				PHYSICIAN'S NAME (Type) <u>F. E. Muser</u> <u>Landover Hills, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2-9-1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wash D.C.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Mattingly</u> ADDRESS <u>131-11th St NE</u>				24. REC'D BY REGISTRAR DATE <u>FEB 9 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





02155

02202

Prince Georges County, Maryland  
Cheverly, D.C.A.  
Beltsville

Prince Georges General Hospital 4515 Bowdoin Mill Road

LOUIS HENRY BIELLOX February 4, 1962

Male White March 21, 1902 22

Resident of Columbia U.S.A.

General

679-28-7509

Prince Georges General Hospital

Prince Georges General Hospital

X X X

JAMES I. SOYD, M.D. February 5, 1962



02190

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02204

## CERTIFICATE OF DEATH

02187

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>5115 Flintwood Drive</b> d. STREET ADDRESS <b>Hyattsville., Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Baby</b>		First Middle Last <b>Boy #A" Booher</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>Feb 7 19 62</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>2 Feb 1962</b>		<b>9. AGE</b> (In years last birthday) yrs. <b>6</b>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>				<b>13. FATHER'S NAME</b> <b>Frank lyn Osear Booher</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Wayne Broucher</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service)			
<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> Address <b>Mother Same</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>776X</b> IMMEDIATE CAUSE (a) <b>Premature Birth (2#3 g)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)							
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>2-2</b> , <b>19 62</b> to <b>2-7</b> , <b>19 62</b> , that (I) (we) last saw the deceased alive on <b>2-7</b> , <b>19 62</b> , and that death occurred at <b>4:35 AM</b> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Dr. Albert J. Modlin</b>				<b>22b. DATE SIGNED</b> <b>2-7 19 62</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Dr. Albert J. Modlin</b>				<b>22d. ADDRESS</b> <b>388 Montrose Avenue, Laurel, Maryland</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Cremation</b>		<b>23b. DATE THEREOF</b> <b>2-17-62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Prince Geo. Gen. Hospital</b>			
<b>23d. LOCATION</b> (City, town or county) <b>Cheverly, Md.</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Harry W. Penn</b>					
<b>25a. REC'D BY REGISTRAR</b> <b>DATE FEB 20 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles S. Perna</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film 307  
2-26-62 ams

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02205

CERTIFICATE OF DEATH

02188

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		d. STREET ADDRESS <b>5115 Flintwood Drive</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy "B"</b> Last <b>Booher</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>5</b> Year <b>19 62.</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2 Feb 1962</b>	
9. AGE (In years last birthday) <b>6 yrs.</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b>Min.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>Frank Oscar Booher</b>				14. MOTHER'S MAIDEN NAME <b>Mary Wayne Broucher</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Same Mother</b>				Address <b>Same as above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>761.5 Prematurity</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Fracture humerus due to injury at birth.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-2</b> <b>19.62</b> to <b>2-5</b> <b>19.62</b> that (I) (we) last saw the deceased alive on <b>2-5</b> <b>19.62</b> , and that death occurred at <b>5:20AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. Albert J. Modlin</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>A. J. Modlin</b>				22d. ADDRESS <b>388 Montrose Avenue, Laurel, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>2-17-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. Gen. Hospital</b>		23d. LOCATION (City, town or county) (State) <b>Cheverly, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harold W. Penn Jr., Administrator</b>				25a. REC'D BY REGISTRAR <b>FEB 20 62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Penn</b>	

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Dr. Wilson, M.D.

538 North Avenue, Miami, Fla.

1944

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02206

## CERTIFICATE OF DEATH

Reg. Dist. No.

02189

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. LENGTH OF STAY IN 1b <i>15 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5408-15th Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>William H. Bosley</i>		4. DATE OF DEATH <i>Feb. 10 1962</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/14, 1868</i>
9. AGE (In years last birthday) <i>93</i>		10. UNDER 1 YEAR <i>Months</i>	11. UNDER 24 HRS. <i>Days</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Elderly, Refinishing picture frames</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Md.</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>William H. Bosley</i>		14. MOTHER'S MAIDEN NAME <i>Ann Foos</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>none</i>		16. SOCIAL SECURITY NO. <i>Charles A. Bosley, son</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myo Cardiac Failure</i> DUE TO (b) <i>Coronary Insufficiency</i> DUE TO (c) <i>Cardio Vascular Renal Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>5 yrs</i> <i>10 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Feb 5, 1962</i> to <i>Feb 10, 1962</i> that I last saw the deceased alive on <i>Feb 10, 1962</i> , and that death occurred at <i>5:30 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert R. Hattel</i> M.D.		ADDRESS (Street, city or town, state) <i>1222 Monroe St 79</i>	
PHYSICIAN'S NAME (Type) <i>Robert R. Hattel</i>		DATE SIGNED <i>Wash DC</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2/13/62</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Suitland, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Malley's Funeral Home</i>		24a. REC'D BY REGISTRAR <i>Mr. Rainier</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Huns</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08180

CERTIFICATE OF DEATH

08180

*[Faint, illegible text, likely bleed-through from the reverse side of the document]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02207

## CERTIFICATE OF DEATH

02190

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
c. LENGTH OF STAY IN 1b 2 months and 14 days				d. STREET ADDRESS 835 46th St., N.E.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Emanuel - Botts				4. DATE OF DEATH 2 20 19 62			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/6/1888	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter Woodward & Lothrop District Bldg.,				11. BIRTHPLACE (County & State, or foreign country) Mo. USA			
13. FATHER'S NAME Fred Botts				14. MOTHER'S MAIDEN NAME Lenora Frakes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 577-01-3961		17. INFORMANT Decedent Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, moderately advanced; cerebrovascular accident, probably thrombosis with left hemiparesis; encephalomalacia due to cerebral arteriosclerosis; decubiti buttocks and feet 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20c. TIME OF INJURY Month, Day, Year 19 12/6/1961 to 2/20/1962		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/6/1961 to 2/20/1962, that (I) (we) last saw the deceased alive on 2/20/1962, and that death occurred at 1:45 P.M., from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss, M.D.				22b. DATE SIGNED 2/20/62			
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2.23.62		23c. NAME OF CEMETERY OR CREMATORY LINCOLN MEM. CEM.		23d. LOCATION (City, town or county) (State) SUITLAND, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Robert G. McGuire				25a. REC'D BY REGISTRAR 1820 9th St. N.W. WASHINGTON, D.C. DATE FEB 23 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Frakes	

03303

03130

CERTIFICATE OF DEATH

EM. DEM.

BURIAL

SWITZERLAND

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Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02208

## CERTIFICATE OF DEATH

02191

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MD.</b> b. COUNTY <b>CHARLES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELINTON</b>		c. LENGTH OF STAY IN lb <b>8 HOURS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b> <b>OPX-2</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SOUTHERN MARYLAND HOSPITAL</b>				d. STREET ADDRESS <b>LA PLATA</b>			
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>G.</b> Last <b>BRANNEN</b>				4. DATE OF DEATH Month <b>FEB</b> Day <b>5</b> Year <b>1962</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 11, 1902</b>	9. AGE (In years last birthday) <b>59 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STORE KEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL STORE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>Denton W. Brannen</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Thomas</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>401-09-5161</b>		17. INFORMANT (Wife) <b>Mrs. Mary M. Brannen - Box 262 La Plata, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> (c) <b>diabetes mellitus</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 years</b> <b>15 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <b>2-5-62</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>2-5-62</b> , 19 <b>62</b> , and that death occurred at <b>8:28 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>F.M. JOHNSON MD</b>				22b. DATE SIGNED <b>2-5-62</b>			
22c. PHYSICIAN'S NAME (Type) <b>F.M. JOHNSON MD</b>				22d. ADDRESS <b>LA PLATA, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/8/1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Memorial Gardens</b>		23d. LOCATION (City, town or county) (State) <b>Waldorf, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Richard Funeral Home, Inc. Md.</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 9 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>	

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General George, General Hospital, 31st Hospital Road  
Chancellor Lord, Secretary  
General, Secretary, Virginia  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02210

## CERTIFICATE OF DEATH

02193

<b>1. PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGE'S</u> <u>MARYLAND</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING, MD</u>				c. LENGTH OF STAY IN 1b <u>22 YEARS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9001 NEW HAMPSHIRE AVE.</u> <u>MISS. MARY SERVANTS MOST HOLY TRINITY</u>				d. STREET ADDRESS <u>9001 NEW HAMPSHIRE AVE</u>			
3. NAME OF DECEASED (Type or print) First <u>LAURENCE</u> Middle <u>THOMAS</u> Last <u>BREDIGER</u>				4. DATE OF DEATH Month <u>FEB.</u> Day <u>9</u> Year <u>1962</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 16, 1911</u>	
9. AGE (In years last birthday) <u>50 yrs.</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CATHOLIC PRIEST.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>		11. BIRTHPLACE (County & State, or foreign country) <u>NEW JERSEY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>FREDERICK BREDIGER</u>				14. MOTHER'S MAIDEN NAME <u>MARIE MAIDEN NAME KATHRINE A KILKENNY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NOTE</u>			
17. INFORMANT <u>FATHER STEPHEN - MISS. SERVANTS</u>				Address <u>most Holy TRINITY</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ATHEROSCLEROSIS</u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN.</u> <u>5 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>FEB. 4, 1953</u> to <u>FEB. 9, 1962</u> , that (I) (we) last saw the deceased alive on <u>FEB. 9, 1962</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>James A. Roberts</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>FEB. 9, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS M.D.</u>				22d. ADDRESS <u>8907 GEORGIA AVE. SILVER SPRING, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-14-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Trinity Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Holy Trinity</u> <u>Alabama</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>				25a. REC'D BY REGISTRAR <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02211

## CERTIFICATE OF DEATH

Item 9 Film G306 2/8/62 ink

02194

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>VIRGINIA</b> b. COUNTY <b>GREENE</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>STANDARDSVILLE</b>	
c. LENGTH OF STAY IN 1b <b>4 WEEKS</b>		d. STREET ADDRESS <b>RT 1 Box 206</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6321 BRANCH AVE, S.E.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EMMA FRANCIS BRILL</b>		4. DATE OF DEATH <b>FEB. 2 1962</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 22 1886</b>
9. AGE (In years, last birthday) <b>75 yrs.</b>		10. IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>GREENBRIAR CO. W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM O'DONOVAN</b>		14. MOTHER'S MAIDEN NAME <b>Mary Carpenter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>(DTR) RAMONA MYERS</b>		Address <b>S.E. 6321 BRANCH AVE.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT (HEMORRHAGE)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b> DUE TO (c) <b>NONE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 HRS.</b> <b>157 YRS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>NONE</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature, if any, of injury) <b>(NOTE: CERTIFICATE SIGNED WITH PERMISSION OF JMS, BOYD MD.)</b>	
20c. TIME OF INJURY Month, Day, Year <b>NONE</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/> elsewhere <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, shop, office, etc.) <b>NONE</b>		20f. (City or town) <b>NONE</b> (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JAN. 1961</b> to <b>PRESENT</b> , that (I) (we) last saw the deceased alive on <b>FEB. 2 1962</b> and that death occurred at <b>1258</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Arthur Shaver Jr. M.D.</b>		22b. DATE SIGNED <b>FEB 2, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR SHAVER JR. MD.</b>		22d. ADDRESS <b>BRANCH AVE, CLINTON, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 2-4-62</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>Standardsville Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Standardsville Va</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Head Close Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Branch Ave</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Shaver</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02212

## CERTIFICATE OF DEATH

02195

<b>1. PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGE</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u> d. STREET ADDRESS <u>1514 - 9th ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>ROY ROBERT BROOKS</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>FEB 2 1962</u> Month Day Year			
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>COLORED</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>JUNE 28 1903</u> <u>58</u> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>GENERAL LABORER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>HOWARD MD</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>EDWARD BROOKS</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>CATHERINE GIBSON</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>705-12-3323</u>		<b>17. INFORMANT</b> <u>GERTRUDE MATTHEWS, LAUREL</u>		<b>Address</b> <u>502 - 9th ST</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>142.0</u> IMMEDIATE CAUSE (a) <u>E. A. RT Parotid</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>7/6</u> , 19 <u>61</u> , to <u>2/2</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>1/23</u> , 19 <u>62</u> , and that death occurred at <u>4 AM</u> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>B. P. Warren</u> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Bryan P. Warren</u>				<b>22d. ADDRESS</b> <u>Laurel</u>		<b>22e. STATE</b> <u>MD</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2/5/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Bacon</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Anne Arundel MD</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Ridgely Kelly</u>				<b>ADDRESS</b> <u>502 - 4th St Laurel</u>		<b>25a. REC'D BY REGISTRAR</b> <u>FEB 6 '62</u>	
				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>			

MEDICAL CERTIFICATION

08150

08150



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02213

## CERTIFICATE OF DEATH

Item 13 Film G310 4/3/62 iwk

02196

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>12 hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>			d. STREET ADDRESS <b>Box 3805</b>		e. 15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Girl</b> Last <b>Brown</b>			4. DATE OF DEATH Month <b>Feb</b> Day <b>6</b> Year <b>19 62</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 Feb 1962</b>	9. AGE (In years last birthday) yrs. <b>12</b>	IF UNDER 1 YEAR Months <b>12</b> Days <b>12</b> Hours <b>12</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Hernand Bernard James Duckett</b>			14. MOTHER'S MAIDEN NAME <b>Pauline Brown</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mother Same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776X Prematurity</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-6-1962</b> , to <b>2-6-1962</b> that (I) (we) last saw the deceased alive on <b>2-6-1962</b> , and that death occurred at <b>10:55 PM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Dr. Albert J. Modlin</b>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>Dr. Albert J. Modlin</b>			22d. ADDRESS <b>388 Montrose Avenue, Laurel, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>2-17-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hosp. Cheverly, Md.</b>	
23d. LOCATION (City, town or county)		23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn Jr., Administrator</b>			25a. REC'D BY REGISTRAR <b>DATE FEB 20 '62</b>		
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			25c. DATE		

VR A15 (4)  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02215 CERTIFICATE OF DEATH 02198									
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>3 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47 Mt. Rainier</b> d. STREET ADDRESS <b>3837 34th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Milton</b>			First Middle Last <b>Bunch</b>		4. DATE OF DEATH Month Day Year <b>February 15 19 62</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-1-1872</b>		9. AGE (In years last birthday) <b>89</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Unknown</b>			16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>		Address <b>Same as #1</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>Unk</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>2-12-62</b> , 19....., to <b>2-15-62</b> , 19....., that (I) (we) last saw the deceased alive on <b>2-15-62</b> , 19....., and that death occurred at <b>3:15 A.</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Dr. Robert B. G. Sasser</b> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <b>P.M.</b>				
22c. PHYSICIAN'S NAME (Type) <b>Dr. Robert B. G. Sasser</b>					22d. ADDRESS <b>R.F.D. Box 2150, Upper Marlboro, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>2/22/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>		
24 FUNERAL DIRECTOR'S SIGNATURE <b>Francis Gasch's Sons</b>					ADDRESS <b>Hyattsville, Maryland</b>		25a. REC'D BY REGISTRAR <b>FEB 23 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. [Signature]</b>

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02216

## CERTIFICATE OF DEATH

Item 9 Film G307 2/26/62 twk

02199

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>7 hrs</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>30 Cedar Heights</b>		
f. STREET ADDRESS <b>1011 62nd Pl.</b>			g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>E</b> Last <b>Burley</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>13</b> Year <b>1962</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Black</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 May 1905</b>		9. AGE (In years last birthday) <b>56</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Anne Arundel Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Charles Smith</b>			14. MOTHER'S M maiden name <b>Unknown</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Augusta Hansberry Some as 2D</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarct</b> DUE TO (b) <b>Arterio sclerosis of the</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>4205</b>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>12 Feb</b> , 1962, to <b>13 Feb</b> , 1962, that (I) (we) last saw the deceased alive on <b>13 Feb 1962</b> , and that death occurred at <b>2,304</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>R.B. Sasscer</b>		M.D.	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Robert B Sasscer., M.D.</b>		22d. ADDRESS <b>R.F.D. Box 2150 Upper Marlboro., Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>2-17-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Masons Cem</b>		23d. LOCATION (City, town or county)	(State) <b>md</b>
24 FUNERAL DIRECTOR'S SIGNATURE <b>H.S. Washington &amp; Son 4925 Deane Ave NE</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 19 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02217

## CERTIFICATE OF DEATH

02200

<b>1. PLACE OF DEATH</b> a. COUNTY Prince Georges MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 644 Eye St., S.E.	
<b>3. NAME OF DECEASED</b> (Type or print) Alexander - Burnside		<b>4. DATE OF DEATH</b> Month 2 Day 8 Year 19 62	
<b>5. SEX</b> Male	<b>6. COLOR OR RACE</b> Negro	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> 4/3/1884
<b>9. AGE</b> (In years last birthday) 77 yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Retired laborer	<b>11. BIRTHPLACE</b> (County & State, or foreign country) S.C.
<b>12. CITIZEN OF WHAT COUNTRY?</b> USA		<b>13. FATHER'S NAME</b> Joe Burnside	
<b>14. MOTHER'S MAIDEN NAME</b> Eloise ?		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) Unknown -	
<b>16. SOCIAL SECURITY NO.</b> 579-18-4736		<b>17. INFORMANT</b> Decedent	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolus 464 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Phlebothrombosis of femoral and iliac vessels DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis; diabetes mellitus; generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 day Unknown	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from 8/11/1961 to 2/8/1962, that (I) (we) last saw the deceased alive on 2/8/1962, and that death occurred at P.M. from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> Moe Weiss		<b>22b. DATE SIGNED</b> 2/8/62	
<b>22c. PHYSICIAN'S NAME</b> (Type) Moe Weiss, M. D.		<b>22d. ADDRESS</b> Glenn Dale Hospital Glenn Dale, Md.	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) Burial		<b>23b. DATE THEREOF</b> 2/9/62	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> Lincoln Memorial		<b>23d. LOCATION</b> (City, town or county) (State) Suitland Md	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> Spangler For Home		<b>25a. REC'D BY REGISTRAR</b> DATE FEB 13 '62	
<b>25b. REGISTRAR'S SIGNATURE</b> Arthur L. Hume			

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02218 Items 1 & 9 Film G307 2/23/62 iwk											
02201											
1. PLACE OF DEATH a. COUNTY <u>Prince Geo. Wash, Chesebrough, MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesebrough, Md.</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Kent Village</u>					
c. LENGTH OF STAY IN lb <u>20 days</u>						d. STREET ADDRESS <u>7214 Forest Road.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's Gen. Hosp.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Jack</u>						4. DATE OF DEATH <u>Feb 13 1962</u>		Month <u>Feb</u> Day <u>13</u> Year <u>1962</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-10-01</u>		9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Durham N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>						14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Louis Howell</u>		Address <u>7212 Forest Rd. Hyattsville, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Coronary Artery Disease</u> (c) <u>Intramural thrombi.</u>										INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>Unk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Brand's pneumonia fatal.</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-24</u> , 19 <u>62</u> to <u>2-13</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>2-13</u> , 19 <u>62</u> and that death occurred at <u>10AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>R J Jarscer</u>						ATTENDING PHYS. <input type="checkbox"/> M.D.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB 16, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodfield Cem.</u>				23d. LOCATION (City, town, or county) (State) <u>Galesville, Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>T A Hardesty + Son</u>				ADDRESS <u>Galesville Md</u>				25a. REC'D BY REGISTRAR <u>FEB 19 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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Handwritten notes and dates, including "10-10-11", "10-13", and "10-14".

Handwritten notes and dates, including "10-15", "10-16", and "10-17".

Handwritten notes and dates, including "10-18", "10-19", and "10-20".

## CERTIFICATE OF DEATH

Reg. Dist. 02202

02219

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. G.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Meadows</u>		c. LENGTH OF STAY IN 1b <u>24 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Meadows</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old Marlboro Pike</u>				d. STREET ADDRESS <u>1 Old Marlboro Pike</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Joseph</u> Last <u>Carroll</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>4</u> Year <u>1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 27, 1895</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>28</u> Hours <u>12</u> Min.	IF UNDER 24 HRS. Months <u>6</u> Days <u>28</u> Hours <u>12</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during <u>Emp. 10 yrs.</u> even if retired) <u> Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A</u>	
13. FATHER'S NAME <u>Joseph Carroll</u>			14. MOTHER'S M maiden NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WWI</u>		16. SOCIAL SECURITY NO. <u>579-204224</u>		INFORMANT <u>Elizabeth C Mulliken</u> Address <u>28 Milan</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Coronary heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 3, 1962</u> to <u>Feb 4, 1962</u> that I last saw the deceased alive on <u>Feb 3, 1962</u> , and that death occurred at <u>520A</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>8200 Marlboro Pike</u> <u>Washington 25, DC</u>					
PHYSICIAN'S NAME (Type) <u>James I. Boyd</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/7/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Ft. Myer, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Fun'l Home-Upper Marlboro,</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 14 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

02318



023015

W. A. L. L. L.



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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02220

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02203

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Carmody Hills</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>28 Carmody Hills</b>			
c. LENGTH OF STAY IN yrs. <b>15 years</b>				d. STREET ADDRESS <b>302 73rd Street</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>302 73rd Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Herbert Collier Coale</b>				4. DATE OF DEATH <b>February 2, 1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 21, 1908</b>	
9. AGE (In years last birthday) <b>53 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance Salesman</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Ralph Coale</b>				14. MOTHER'S MAIDEN NAME <b>Lillian Shepherd</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>577-03-7005</b>			
17. INFORMANT <b>Thelma Louise Coale</b>				Address <b>3630 31st Street NE Washington D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO (b) <b>Gun shot wound of the head</b> DUE TO (c) <b>Shot self in the head, while in his home</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> <b>Not While at work</b> <input checked="" type="checkbox"/> 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b> 20e. (City or town) <b>Carmody Hills</b> (County) <b>P.G.</b> (State) <b>Md</b> 20f. (City or town) <b>Carmody Hills</b> (County) <b>P.G.</b> (State) <b>Md</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				DATE SIGNED <b>2/2/62</b>			
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>burial</b>				22b. DATE THEREOF <b>2/6/62</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>				22d. LOCATION (City, town, or country) <b>Pr. Geo. Co., Maryland</b>			
23. FUNERAL DIRECTOR <b>The S.H. Hines Co., 2901 14th St. N.W.</b>				24. REC'D BY REGISTRAR <b>Arthur S. Hines</b>			
24b. REGISTRAR'S SIGNATURE <b>666</b>				DATE <b>FEB 6 '62</b>			

VS. A15ME  
5M 9/60

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02221

## CERTIFICATE OF DEATH

02204

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b> c. LENGTH OF STAY in 1b <b>4 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>-</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>Little Sisters of the Poor</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Leo</b> Middle <b>-</b> Last <b>Corriden</b>				4. DATE OF DEATH Month <b>2</b> Day <b>20</b> Year <b>19 62</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>2/12/01</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b>		IF UNDER 24 HRS. Hours <b>-</b> Min. <b>-</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>			
17. INFORMANT <b>Decedent</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive gastrointestinal hemorrhage, etiology undetermined</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>578X</b> (c) <b>undetermined</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Cerebrovascular accident with right hemiparalysis; bronchopneumonia; chronic alcoholism; myocardial infarction, historical; auricular fibrillation.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>ation.</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>10:28</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>2/16/1962</b>		20f. (City or town) (County) (State) <b>1962</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>2/16/1962</b> to <b>2/20/1962</b> , that (I) (we) last saw the deceased alive on <b>2/20/1962</b> , and that death occurred at <b>10:28 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Moe Weiss</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/20/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>				22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 23<sup>rd</sup> 62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>McLure Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Wash. D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Costello</b>				ADDRESS <b>1722 N Capital Wash. D.C.</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 23 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02222

CERTIFICATE OF DEATH

02205

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>13 hrs</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>5330 Q St.</b>			
3. NAME OF DECEASED (Type or print) <b>Margaret V Cunico</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>20</b> Year <b>19 62</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2 Oct. 1900</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b>		IF UNDER 24 HRS. Hours <b>19</b> Min. <b>62</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Starkville, Colorado</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Dominick Boccaccio</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give number or date of service)		17. INFORMANT <b>John Cunico-husband as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>200.0</b> IMMEDIATE CAUSE (a) <b>Reticulum Cell Sarcoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-12-1962</b> to <b>2-20-1962</b> , that (I) (we) last saw the deceased alive on <b>2-19-1962</b> , and that death occurred at <b>1:30AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Peter Duus</b>				22b. DATE SIGNED <b>2-20-62</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Peter Duus, M.D.</b>				22d. ADDRESS <b>6124 Central Avenue Capitol Heights., Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/23/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION (City, town or county) (State) <b>Greenbelt, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home - Washington D.C.</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 23 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

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1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02223 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02206

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edmonston			
c. LENGTH OF STAY IN lb D.O.A.				d. STREET ADDRESS 5121 Decatur			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Virginia Barcus		First Middle Last		4. DATE OF DEATH February 2 19 62		Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1916	9. AGE (in years last birthday) 45 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 27 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Idaho		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME KNOWN Barcus				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give number or date of service)		17. INFORMANT Address Howard Depue Dalzell			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA 490X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SEVERE FATTY LIVER, ALCOHOLISM							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/2/62	
EXAMINER'S NAME (Type) James I. Boyd				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2-3-1962		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State) Manassas Virginia	
23. FUNERAL DIRECTOR ADDRESS Baker & Son Funeral Home Manassas, Virginia				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE FEB 6 '62		Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

805580

STATE OF NEW YORK

28990

DATE 1961



NOTICE OF

1961

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1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY		Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		Maryland b. COUNTY				Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		District Height				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		District Heights				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		7815 Gateway Boulevard				d. STREET ADDRESS		7815 Gateway Boulevard					
3. NAME OF DECEASED (Type or print)		Claire Elizabeth de Lorimier				4. DATE OF DEATH		February 10, 19 62					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		December 24, 1889		72 yrs.		Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Housewife		At Home		New Jersey		U.S.A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
George Van Gilder		Elizabeth Rohrbach		No		None		Frank Berford Evans		Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 4 2 X Acute congestive heart failure													
Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease													
cause last, stating the underlying (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19													
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				JAMES I. BOYD, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type)				JAMES I. BOYD, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				2/10/62	
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
								Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country)		(State)					
Burial		2-13-1962		Washington, National		Suitland, Maryland							
23. FUNERAL DIRECTOR				ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
W.W. Chambers Co. Riverdale, Md.								FEB 13 '62		Arthur S. Klaus			

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02225

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02208

1  
FOR STATE  
HEALTH DEPT.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>2 1/2 Hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges Gen. Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u> d. STREET ADDRESS <u>Box 3411 Star Route</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) <u>ALICE LOUISE DIGGS</u>		<b>4. DATE OF DEATH</b> <u>Feb. 2, 1962</u> 19		<b>5. SEX</b> <u>Fem.</u>		<b>6. COLOR OR RACE</b> <u>Colored</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>May 15, 1896</u>		<b>9. AGE</b> (In years last birthday) <u>66</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.																		
Months	Days																		
Hours	Min.																		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House Wife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>At Home</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>															
<b>13. FATHER'S NAME</b> <u>Richard Brown</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Jane Forbes</u>															
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b> Address <u>Pittchellville, Md</u> <u>Mrs. Margret Blake Route #2 Box 114</u>															
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary heart disease</u> DUE TO (c) <u>Cardiovascular renal disease</u>																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Diabetes of long duration</u>																			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)															
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)											
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>ACTUAL SIGNATURE</b> <u>James I. Boyd</u> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME</b> (Type) <u>James I. Boyd</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <u>2/3/62</u> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> Address (Street, city, town, or county)																			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>				<b>22b. DATE THEREOF</b> <u>2-7-62</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>MT. CARMEL</u>		<b>22d. LOCATION</b> (City, town, or country) (State) <u>UPPER MARLBORO, MD.</u>											
<b>23. FUNERAL DIRECTOR</b> <u>MYRTLE K. ROLLINS</u>				<b>ADDRESS</b> <u>WASH., D.C.</u>				<b>24e. REC'D BY REGISTRAR</b> <u>FER 5 '62</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur E. Hanna</u>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03508

03508



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, page 1, 2, and 3 to the funeral director, page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02226

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02209

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 70 College Park			
c. LENGTH OF STAY IN 1b D.O.A.				d. STREET ADDRESS 8707 50th., Place			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Olin Andrew Dovel				4. DATE OF DEATH February 12, 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6, 1897	
9. AGE (In years last birthday) 64 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine Insurance Ex. Maritime Commission		10b. KIND OF BUSINESS OR INDUSTRY Virginia		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME George Washington Dovel				14. MOTHER'S MAIDEN NAME Cora Virginia Snyder			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW 1				16. SOCIAL SECURITY NO. 577-26-9212			
17. INFORMANT Mary Dovel, same as # 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				DATE SIGNED 2/12/62			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/12/62		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or country) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR Francis Gasch's Sons				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE			
ADDRESS Hyattsville, Maryland				DATE FEB 13 '62			

MEDICAL CERTIFICATION

2

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60550

60550

Francis Carson's Bone, Lysiville, Kentucky

Lincoln

2/15/62

Burial

Colonel Francis

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02227  
CERTIFICATE OF DEATH  
02210

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 15 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 36 Seabrook d. STREET ADDRESS 9603 Franklin Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Melba B. Duncan		4. DATE OF DEATH Month Day Year February 13 19 62			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-24-1907	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY College Instructor		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A			13. FATHER'S NAME J Ed Blake		
14. MOTHER'S MAIDEN NAME Cora Burgess			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Hospital Records Cheverly, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 60-27 DUE TO (b) uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Renal Insufficiency PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pyelonephritis and Hypertension INTERVAL BETWEEN ONSET AND DEATH					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/29 1962 to 2/13 1962 that (I) (we) last saw the deceased alive on 2/13 1962, and that death occurred at 12:38 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Louis B. Bachrach M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED Feb 13-1962		22c. PHYSICIAN'S NAME (Type) Dr. Louis B. Bachrach	
22d. ADDRESS 915 19th St., N.W., Washington 6, D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 17, 1962		23c. NAME OF CEMETERY OR CREMATORY High Lawn Memorial Park	
23d. LOCATION (City, town or county) (State) Oak Hill West Virginia					
24 FUNERAL DIRECTOR'S SIGNATURE Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE FEB 15 '62	
25b. REGISTRAR'S SIGNATURE Charles P. House					

C. SSV<sup>2</sup>

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1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME  
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02228 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02211

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN lb <b>D.O.A.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>William Albert Elliott</b>		4. DATE OF DEATH <b>February 25 1962</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 8, 1914</b>		9. AGE (In years last birthday) <b>48 yrs.</b>		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Appliance</b>		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William David Elliott</b>				14. MOTHER'S MAIDEN NAME <b>Ann Elizabeth Talmadge</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>578-05-4851</b>			
17. INFORMANT <b>Ruth Elliott, same as # 2</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertensive heart disease</b> (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>2/25/62</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-28-1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town, or country) (State) <b>Bladensburg, Md.</b>	
23. FUNERAL DIRECTOR <b>W. W. Chambers Co. Riverdale, Md.</b>				24a. REC'D BY REGISTRAR <b>1 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ISM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02229

02212

1. PLACE OF DEATH o. COUNTY Prince George County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Prince Geo ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10105 Green Forest Drive		d. STREET ADDRESS 1 10105 Green Forest Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last FARROW		4. DATE OF DEATH Month Feb. Day 16 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1961
9. AGE (In years lost birthday) yrs. 1		10. IF UNDER 1 YEAR Months 11 Days Hours Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at Home		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Walter R. Farrow		14. MOTHER'S MAIDEN NAME Rose Mayewski	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Address Walter R. Farrow (same as #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493X Acute, Fulminating Pneumonia DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mongolianism		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar, 7, 1962, to Feb. 16, 1962, that (I) (we) lost saw the deceased alive on 2/16, 1962, and that death occurred 6:05 P.M., from the causes and on the date stated above.			
22a. SIGNATURE James H. Haubach M.D.		22b. DATE SIGNED 2/16/62	
22c. PHYSICIAN'S NAME (Type) James H. Haubach, M.D.		22d. ADDRESS 1806 Fox St Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 17, 1962	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters, 28 Carroll St NW, DC		25. REC'D BY REGISTRAR DATE FEB 19 1962	
25. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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**1**  
**FOR STATE**  
**HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**02230**

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**02213**

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hayler</u>				c. LENGTH OF STAY IN 1b <u>Hayler</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Route 382</u>				d. STREET ADDRESS <u>Route 382</u>			
3. NAME OF DECEASED (Type or print) <u>Wright John Ferguson</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>2</u> Year <u>1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 17, 1909</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work doing most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.E</u>							
13. FATHER'S NAME <u>John Ferguson</u>				14. MOTHER'S MAIDEN NAME <u>Florence Wright</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-26-8559</u>			
				17. INFORMANT <u>Elizabeth Ferguson</u> Address <u>same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443</u> DUE TO <u>Acute Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Hypertensive heart disease</u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>Feb 2, 1962</u>			
ACTUAL SIGNATURE <u>James T. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES T. BOYD</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county) <u>  </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 5/19/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas</u>		22d. LOCATION (City, town, or county) (State) <u>Aguasco Md. R.D. 1</u>	
23. FUNERAL DIRECTOR <u>George H. Kelson</u>				24a. REC'D BY REGISTRAR <u>Feb 7 '62</u>			
ADDRESS <u>Aguasco Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

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STATE OF TEXAS  
COUNTY OF DALLAS

08213

STATE OF TEXAS  
COUNTY OF DALLAS



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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02231

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02214

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville 60	
c. LENGTH OF STAY IN lb D.O.A.		d. STREET ADDRESS 5608 29th Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lovie JacquelineFlesher		4. DATE OF DEATH Month Day Year February 10 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 28, 01 61
9. AGE (In years last birthday) 60		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Food	11. BIRTHPLACE (State or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Gordon Hannigan		14. MOTHER'S MAIDEN NAME Willa Lee Turner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-36-9407	
17. INFORMANT Nancy Goddard, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Artery Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2/11/62 Address (Street, city, town, or county)			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James I. Boyd		22a. NAME OF CEMETERY 22b. DATE THEREOF Feb. 14, 1962 22c. LOCATION (City, town, or country) (State) Bladensburg, Maryland.	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO. Riverdale, Md.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE FEB 13 '62	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, page 1, 2, and 3 to the funeral director. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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W. W. CHAMBERS CO. BAYTOWN, MO.  
Burial Feb. 14, 1905 East Lincoln Cemetery, St. Louis, Mo.  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# 1 M 77 M 02232 02215 **MARYLAND STATE DEPARTMENT OF HEALTH** **DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND** **CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 55 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanover		d. STREET ADDRESS 1600 Whitehouse Heights	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Minerva ELIZABETH Fletcher		4. DATE OF DEATH February 18 19 62		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/25/92		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Power		14. MOTHER'S MAIDEN NAME Belle Schumate		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr Samuel Fletcher		Address Home # 2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 60080 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Kidney insufficiency (c) bilateral pyelonephritis & nephrosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Rheumatoid arthritis - Pulmonary emphysema			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 12-28 1962, to 2-18 1962, that (I) (we) last saw the deceased alive on 2-18 1962, and that death occurred at 6:55 PM from the causes and on the date stated above.	
22a. SIGNATURE Ottavio Gelmi		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Dr. Ottavio Gelmi		22d. ADDRESS 1801 Eye St., N. W., Washington, D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-21-1962		23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION (City, town or county) Scutland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Pimlico, Md.		25a. REC'D BY REGISTRAR DATE FEB 23 '62		25b. REGISTRAR'S SIGNATURE Arthur S. House		25c. ADDRESS	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02233

02216

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN b. <b>19 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheltenham</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>Box 25</b>			
3. NAME OF DECEASED (Type or print) <b>Charles L Foreman</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>27</b> Year <b>19 62</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>NEGRO Black</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8 April 1882</b>	
				9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months <b></b> Days <b></b>	
				11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired MESSENGER U. S. SUPREME CT.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>WASHINGTON, D.C.</b>			
13. FATHER'S NAME <b>? FOREMAN</b>				14. MOTHER'S MAIDEN NAME <b>VICTORIA ?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>MARY FOREMAN-WIFE</b> Address <b>Box 25 CHELTENHAM, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio-vascular-renal disease</b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
2De. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. <b></b> p.m. <b>19</b>		2Dd. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8 Feb</b> 19 <b>62</b> to <b>27 Feb</b> 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>27 Feb</b> 19 <b>62</b> , and that death occurred at <b>2:50 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>R. R. Sasscer</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. R. Sasscer., M.D.</b>				22d. ADDRESS <b>Upper Marlboro., Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-3-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LINCOLN MEMORIAL</b>		23d. LOCATION (City, town or county) (State) <b>SUITLAND, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Alex S. Pope, Jr.</b>				ADDRESS <b>414-15<sup>TH</sup> S.E.</b>		25a. REC'D BY REGISTRAR <b>MAR 1 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			



08833

Prince Georges

Obituary

12 days

Prince Georges Memorial Hospital

Charles

Posthumous

Feb

27

1 April 1982

28

27

Princess Margaret & Sir John MacGillivray  
FOREMAN

Princess Margaret & Sir John MacGillivray  
FOREMAN

Princess Margaret & Sir John MacGillivray  
FOREMAN

Princess Margaret & Sir John MacGillivray  
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FOREMAN

Princess Margaret & Sir John MacGillivray  
FOREMAN

Princess Margaret & Sir John MacGillivray  
FOREMAN

Princess Margaret & Sir John MacGillivray  
FOREMAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02234

## CERTIFICATE OF DEATH

Reg. Dist. No. 02217

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>West Hyattsville</i>		c. LENGTH OF STAY IN 1b <i>9 years</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>58 West Hyattsville</i>		d. STREET ADDRESS <i>12421 Chapman Rd.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2421 Chapman Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>MARIE</i> Middle <i>JOHANNA HENRIETTA</i> Last <i>Giesbecke</i>		4. DATE OF DEATH Month <i>February</i> Day <i>22</i> Year <i>1962</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>cauc.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 9, 1873</i>
9. AGE (In years lost birthday) yrs. <i>88</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Germany</i>	
13. FATHER'S NAME <i>Johann George</i>		12. CITIZEN OF WHAT COUNTRY? <i>Germany</i>	
14. MOTHER'S MAIDEN NAME <i>Maria Winter</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Catchen Bolick</i> Address <i>2421 Chapman Rd., West Hyattsville</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral arteriosclerosis</i> DUE TO (c) <i>Generalized arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>unknown</i> <i>unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i>o. ft.</i> p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Febr. 21, 1962</i> , to <i>Febr. 22, 1962</i> , that I last saw the deceased alive on <i>Febr. 21, 1962</i> , and that death occurred at <i>1:05 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Eino Magi</i>		ADDRESS (Street, city or town, state) <i>918 University Blvd. E., Silver Spring, Md.</i>	
PHYSICIAN'S NAME (Type) <i>EINO MAGI</i>		DATE SIGNED <i>2-22-62</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-24-62</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Colman Manor Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Basch's Sons</i>		ADDRESS <i>Hyattsville Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>FEB 26 '62</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Keane</i>	



1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

02235

02218

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 61			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5402-38th Ave</u>				d. STREET ADDRESS <u>5402-38th Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward Andrew Gross</u>				4. DATE OF DEATH Month Day Year <u>Febr 2 1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 21, 1895</u> 66 yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Accountant</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>George Gross</u>				14. MOTHER'S MAIDEN NAME <u>Eva Schlundt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>XXXX-XX-XXXX</u>			
17. INFORMANT <u>Eutruide S. Gross</u> Address <u>Same as # 2 -</u>							
18. CAUSE OF DEATH [Enter only one cause, or line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic bronchogenic carcinoma</u> DUE TO <u>162.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>February 1, 1960</u> to <u>Feb 2, 1962</u> that (I) ( <del>was</del> ) last saw the deceased alive on <u>2-1</u> 19 <u>62</u> and that death occurred at <u>3:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Harry N. Carlton</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/2/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>HARRY N. CARLTON</u>				22d. ADDRESS <u>940-25th St, N.W. Wash DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/5/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Lincoln</u>		23d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Guscha Sons Hyattsville Md</u> ADDRESS				25a. REC'D BY REGISTRAR DATE <u>FEB 5 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

(M)

(I)



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02236

02219

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edmonston</u> c. LENGTH OF STAY IN 1b <u>25 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4817 48th Ave</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edmonston</u> <u>63</u> d. STREET ADDRESS <u>4817 48th Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Gladys M. Hall</u>		<b>4. DATE OF DEATH</b> Month <u>Feb</u> Day <u>4</u> Year <u>1962</u>		<b>5. SEX</b> <u>FEMALE</u>			
<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>May 31, 1906</u>			
<b>9. AGE</b> (In years last birthday) <u>55</u> yrs.                 IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>house wife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>own home</u>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Lynchburg Va.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Wade Mc Kenney</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Lora ?</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no.</u>		<b>16. SOCIAL SECURITY NO.</b> <u>  </u>			
<b>17. INFORMANT</b> <u>husband</u> Address <u>James Hall 4817 48th Ave</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> DUE TO (b) <u>Bronchogenic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
<b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u>		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>July 1955</u> <b>to</b> <u>Feb 4, 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Feb 3, 1962</u> <b>and that death occurred at</b> <u>1:40 PM</u> <b>from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <u>Norman Donat Comeau</u> M.D.		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>2/4/62</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>NORMAN DONAT COMEAU</u>		<b>22d. ADDRESS</b> <u>3503 Penny ST Mt. Rainier Md</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Feb 1962</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Lincoln</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Colman Manor, Md</u> (State) <u>  </u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Flaschi sone Hyattsville Md</u> ADDRESS <u>  </u>					
<b>25a. REC'D BY REGISTRAR</b> <u>  </u> DATE <u>7 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Harris</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

66297

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

02237

CERTIFICATE OF DEATH

02220

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Pennsylvania</b> b. COUNTY <b>Fayette</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxon Hill, Md.</b>		c. LENGTH OF STAY IN 1b <b>3 mo</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>212 Standish Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Millie</b> Middle <b>M</b> Last <b>Hall</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>20</b> Year <b>1962</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 18 1890</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min. <b>71</b>	11. IF UNDER 24 HRS. Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min. <b>71</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jackson Myers</b>		14. MOTHER'S MAIDEN NAME <b>Ella Woodnancy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>	
17. INFORMANT <b>Mrs Vera Groff 212 Standish Dr.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEART ARREST</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CEREBRO VASCULAR ACCIDENT</b> DUE TO (c) <b>HYPERTENSIVE ARTERIO SCLEROTIC DISEASE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>YEARS.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 28, 1961</b> to <b>Feb. 20, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb. 20, 1962</b> and that death occurred at <b>A. M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Miguel A. Huici</b>		22b. DATE SIGNED <b>2/20/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Miguel A Huici, M.D.</b>		22d. ADDRESS <b>5234 Livingston Rd., S.E.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 23 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Johnson Chapel</b>	23d. LOCATION (City, town, or county) (State) <b>Fayette Co. Penna.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Pearson Funeral Home, Falls Church, Va.</b>		25a. REC'D BY REGISTRAR <b>FEB 21 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

02220

STATE OF TEXAS

02220

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02238 CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN 1b 4yrs. 10mos. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Home					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE -- b. COUNTY -- c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 4207 Ellicott Street, NW e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Katherine First Middle Last Hanson			4. DATE OF DEATH February 22 1962 Month Day Year						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 18, 1879		9. AGE (In years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Waxford Co., Ireland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Doyle				14. MOTHER'S MAIDEN NAME Margaret Foley					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Sacred Heart Home Records-#1 abv Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 2/19/1958-2/22/1962		20g. (County) 19	
21. I certify that (I) (the hospital) attended the deceased from 2/21/1962 4:40 A.M. to 2/22/1962 4:40 A.M., that (I) (the hospital) saw the deceased alive on 2/21/1962 19, and that death occurred at 4:40 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Thomas F. Collins M.D.				22b. DATE SIGNED 2/22/1962		22c. PHYSICIAN'S NAME (Type) Thomas F. Collins, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/24/62		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION (City, town or county) (State) Washington, D.C.			
24. FUNERAL DIRECTOR'S SIGNATURE Jas. T. Ryan, Inc.				24a. REC'D BY REGISTRAR DATE FEB 26 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Kenna			

1933

James George

Hayesville

Isabel Heart Home

Eschewing

Female White

Housesville

James Doyle

no

none

Isabel Heart Home Hayesville

Aspleniochloa Heart Disease

11 years

Washington, D.C.

Ayre, Iowa

1307 Illinois Street, W

Hendon

February 22

Oct. 13, 1870

Wexford Co., Ireland

USA

Marshall County

5/19/1933 - 5/25/1933

1:40 A.M.

5/21/1933

5/25/1933

322-H. B. D. C. - W. B. S. D. C.

Thomas T. Collins, M.D.

Washington, D.C.

Mr. Oliver

5/25/33

317 Pa. Ave., SE

Jas. T. Ryan, Inc.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

2 1  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02239 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02222

1. PLACE OF DEATH e. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bladensburg		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bladensburg 40	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4105 53rd Avenue		d. STREET ADDRESS 4105 53rd Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Ida Karlstad Harley		4. DATE OF DEATH Month Day Year February 17 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1895
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) South Dakota		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin M. Karlstad		14. MOTHER'S MAIDEN NAME Regina Hoff	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give number or date of service) no	
17. INFORMANT Donald Charshee, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 60 8.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PYELONEPHRITIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FATTY INFILTRATION LIVER 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) James I. Boyd Feb. 17, 1962			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/21/62	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Maryland	
24a. REC'D BY REGISTRAR FEB 20 '62		24b. REGISTRAR'S SIGNATURE C. S. Harris	



1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u>		c. LENGTH OF STAY IN 1b <u>2 month</u>													
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2525 Colebrooke Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) <u>James Bartlett Harrell</u>		<b>4. DATE OF DEATH</b> Month <u>Feb</u> Day <u>17</u> Year <u>1962</u>													
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>													
<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Dec 15, 1961</u>													
<b>9. AGE</b> (In years last birthday) <u>2</u> yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td><u>2</u></td> <td><u>2</u></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<u>2</u>	<u>2</u>			<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.													
Months	Days	Hours	Min.												
<u>2</u>	<u>2</u>														
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>District of Columbia U. S. A.</u>													
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>		<b>13. FATHER'S NAME</b> <u>Hardee Le Roy Harrell</u>													
<b>14. MOTHER'S MAIDEN NAME</b> <u>Marylin Skennard</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>None</u> (If yes give year or dates of service)													
<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Mrs. Marilyn S. Harrell, Son's 2</u>													
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of Injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> e.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>													
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)													
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
<b>ACTUAL SIGNATURE</b> <u>James I. Boyd</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>													
<b>EXAMINER'S NAME</b> (Type) <u>JAMES I. BOYD</u>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>													
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <u>2/17/62</u>													
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Feb. 20-62</u>													
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington Natl.</u>		<b>22d. LOCATION</b> (City, town, or country) (State) <u>Arlington Va</u>													
<b>23. FUNERAL DIRECTOR</b> <u>Simmons Bros.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>1661 - Good Hope Rd SE</u>													
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>		<b>DATE</b> <u>FEB 19 1962</u>													

## MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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02241

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02224

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Florida</b> b. COUNTY <b>Highlands</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Andrews Air Force Base</b>		c. LENGTH OF STAY IN 1b <b>Several days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>USAF Hospital, Andrews AF Base</b>		d. STREET ADDRESS <b>Route 1, Box 354</b>	
3. NAME OF DECEASED (Type or print) First <b>ELEANOR</b> Middle <b>ELIZABETH</b> Last <b>HARRIS</b>		4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 April 1894</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>18</b> Hours <b>30</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wayne Pinkerton</b>		14. MOTHER'S MAIDEN NAME <b>Mary Lee</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Wayne P. Litz (As above)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse</b> <b>164X</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Superior Vena Cava Obstruction</b> (c) <b>Mediastinal neoplasia - possibly metastatic</b>		INTERVAL BETWEEN ONSET AND DEATH <b>JUNE 1961 To 20 FEB '62</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>		20f. (City or town) (County) (State) <b>-</b>	
21. I certify that (I) (the hospital) attended the deceased from <b>10:35 20 FEB. 19 62</b> to <b>10:40 20 FEB 19 62</b> that (I) (we) last saw the deceased alive on <b>10:35 AM 20 FEB 19 62</b> , and that death occurred at <b>11:00 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>William K. Grove Capt USAF MC FMD</b> M.D.		22b. DATE SIGNED <b>20 FEB 19 62</b>	
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM K. GROVE, Capt USAF MC</b>		22d. ADDRESS <b>USAF Hospital, Andrews AFB</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>27 FEB. 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>LAKE PLACID CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>LAKE PLACID FLORIDA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>RINALDI FUNERAL HOME INC.</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 23 '62</b>	
ADDRESS <b>7401 GEORGIA AVE. NW, DC 12</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
5M 9/60

<div>Item 20 Film 307 2-26-62</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>02242</div> <div>02225</div>											
1. PLACE OF DEATH e. COUNTY <b>Prince George's</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Princee George's</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>						c. LENGTH OF STAY IN 1b <b>X</b> <b>Hillside</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6301 Marlboro Pike S.E.</b>						d. STREET ADDRESS <b>1</b>					
3. NAME OF DECEASED (Type or print) <b>Richard Newton Hayes</b>						4. DATE OF DEATH Month <b>February</b> Day <b>19</b> Year <b>19 62</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 14, 1895</b>		9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Newton Hayes</b>						14. MOTHER'S MAIDEN NAME <b>Marion W Hagan</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b> <b>W.W.I</b>						16. SOCIAL SECURITY NO. <b>9574-032002</b>					
17. INFORMANT <b>Esther Richardson</b>						2209 Jamerson St. Hillcrest Hghts, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> 916.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Universal Burns of the body</b> (c) DUE TO (e), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Living in an abandoned bus that caught on fire</b>							
20c. TIME OF INJURY Month, Day, Year <b>10:15</b> <b>2-17</b> <b>19 62</b> Hour <b>p.m.</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>6301 Marlboro Pike S.E. Oakland</b>		20f. (City or town) <b>Pr. Geo.</b> (County) <b>Md.</b> (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>James I. Boyd</b> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>James I. Boyd</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Feb. 17, 1962</b>					
						Address (Street, city, town, or county)					
22b. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>2-23-1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>				22d. LOCATION (City, town, or country) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR <b>W.W. Chambers Co. Riverdale, Md.</b>						24a. REC'D BY REGISTRAR <b>FEB 23 '62</b> 24b. REGISTRAR'S SIGNATURE <b>Charles S. House</b>					

MEDICAL CERTIFICATION

(M)

(M)

2009 Jamerson St.  
Baltimore, Md.

Bethel Richardson

W.M.I.

Yes

Patton W. Ryan

Richardson W. Ryan

Construction Maryland

Construction

James O. Ryan, Jr. 1955

Robert Newton

Robert

Robert

William

William

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G307 2/20/62 iwk

## CERTIFICATE OF DEATH

Reg. Dist. No. 02226

02243

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Washington 11 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Washington 11 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Geo. Co. Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carnie Jones Henson</u>		4. DATE OF DEATH Month Day Year <u>Feb 14 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28 1868</u>
9. AGE (In years last birthday) yrs. <u>93</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dressmaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Providence R.I.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William H. Henson</u>		14. MOTHER'S MAIDEN NAME <u>Leticia Small</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Records Prince Geo. Co. Rest Home</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Anterio Sclerotic Cardiovascular Renal Disease</u> DUE TO (c) <u>(Senile)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>unknown</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Natural Causes</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>— 19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>62</u> to <u>Feb 14</u> , 19 <u>62</u> that I last saw the deceased alive on <u>Feb 12</u> , 19 <u>62</u> , and that death occurred at <u>9:10</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>5440 Silver Hill Rd SE Washington 28 DC.</u>			
ACTUAL SIGNATURE <u>Paul C VanNatta</u> M.D.		22. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
PHYSICIAN'S NAME (Type) <u>PAUL C VAN NATTA</u>		22a. REC'D BY REGISTRAR DATE <u>FEB 16 '62</u>	
22b. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT Olivet</u>	
22d. DATE THEREOF <u>2-16-62</u>		22e. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt &amp; Funeral Home, WADDOF, MD.</u>		24. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>	

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02244

02227

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) enroute to Hospital c. LENGTH OF STAY IN lb D. O. A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 9744 52nd Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elwin First Middle Last Holcombe		4. DATE OF DEATH Month Day Year Feb. 8 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 10, 1921 9. AGE (In years last birthday) 40 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector Navy Dept		11. BIRTHPLACE (County & State, or foreign country) Georgia 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J. Carl Holcombe		14. MOTHER'S MAIDEN NAME Lulu Belle Ridings	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1941 -		16. SOCIAL SECURITY NO. 1941 -	
17. INFORMANT Mrs. Louise Holcombe		Address (same)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Kimmelstiel-Wilson Disease (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 6 months 5 years 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October, 1961, to Feb. 8, 1962, that (I) (we) last saw the deceased alive on Feb. 1, 1962, and that death occurred at 11:00 AM from the causes and on the date stated above.			
22a. SIGNATURE J. Frederick Barr M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J. Frederick BARR, MD		22d. ADDRESS 4500 College Ave, College Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		23b. DATE THEREOF 2/8/62	
23c. NAME OF CEMETERY OR CREMATORY Canton		23d. LOCATION (City, town or county) (State) Georgia	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR DATE FEB 13 '62	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

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CRIMINAL RECORDS

1925

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Mr. Carl Holcomb  
New York City  
New York City  
New York City

Mr. Carl Holcomb  
New York City  
New York City  
New York City

Mr. Carl Holcomb  
New York City  
New York City  
New York City

Mr. Carl Holcomb  
New York City  
New York City  
New York City

Mr. Carl Holcomb  
New York City  
New York City  
New York City

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02245

Item 8 Film G308 3/7/62 jwk

02228

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>66 2215 E Riverdale</b> d. STREET ADDRESS <b>6215 61st Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Paul</b> First <b>Holeva</b> Last 4. DATE OF DEATH <b>Feb 24 1962</b> Month Day Year		5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>1876</b> 9. AGE (In years last birthday) <b>85 yrs.</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Unknown</b> 12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>		13. FATHER'S NAME <b>Unknown</b> 14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Unknown</b> 16. SOCIAL SECURITY NO. <b>Unknown</b> 17. INFORMANT <b>Hospital Records</b> Address <b>Cheverly, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>congestive heart failure</b> (c) <b>arteriosclerotic heart disease</b> <b>generalized arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>1</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>2-22</b> to <b>2-24</b> , 1962, that (I) (we) last saw the deceased alive on <b>2-24</b> 1962, and that death occurred at <b>1.10AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. M. Madarang</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Dr. M. Madarang</b>		22b. DATE SIGNED ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>Prince George's General Hosp., Cheverly, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>2/28/61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b> 23d. LOCATION (City, town or county) <b>Colmar Manor Md.</b> (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 1 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

03258

03258



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Geographic test failure  
Geographic test failure  
Geographic test failure

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Geographic test failure

Unknown

Unknown

Unknown

Unknown

Unknown

As Mr. Paul Haleva had no living  
relatives and a friend Mr. Alexander Hamilton  
assumed responability for the funeral we were  
unable to gather any further information for  
the death certificate

*from the desk of* \_\_\_\_\_

WM. ERNEST GASCH

to Mr. Paul Holsen had no living  
relatives and a friend Mr. Alexander Hamilton  
assumed responsibility for the funeral we were  
unable to gather any further information for  
the State authorities

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02246

02229

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>DC</b> b. COUNTY <b>DISTRICT OF COLUMBIA</b> Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>				c. LENGTH OF STAY IN 1b <b>1 DAY</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US AIR FORCE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>HARROLD LUTHER HOLTMAHN</b>				4. DATE OF DEATH Month Day Year <b>FEBRUARY 6 19 62</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>17 SEPTEMBER 1920</b>	
9. AGE (In years lost birthday) <b>41</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OFFICER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>US AIR FORCE</b>		11. BIRTHPLACE (State or foreign country) <b>OKLAHOMA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>KATHRYN MARIE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>1943-PRESENT 442-16-3413</b>		17. INFORMANT <b>PERSONNEL RECORDS</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEMORRHAGIC DIATHESIS</b> <b>583 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CHRONIC DECOMPENSATED LIVER DISEASE</b> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>20 HOURS</b>  <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>5 FEBRUARY 19 62</b>	
20f. (City or town) (County) (State) <b>6 FEBRUARY 19 62</b>				20g. (City or town) (County) (State) <b>6 FEBRUARY 19 62</b>			
21. I certify that (I) <del>(MRS. HOLTMAHN)</del> attended the deceased from <b>5 FEBRUARY 19 62</b> to <b>6 FEBRUARY 19 62</b> , that (I) <del>(XX)</del> last saw the deceased alive on <b>6 FEBRUARY 19 62</b> , and that death occurred at <b>6P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Bernard F. Clowdus</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6 FEB 62</b>	
22c. PHYSICIAN'S NAME (Type) <b>BERNARD F CLOWDUS, Capt USAF MC</b>				22d. ADDRESS <b>USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>SHIP. RR.</b>		23b. DATE THEREOF <b>2-8-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MUSKOGEE OKLAHOMA</b>		23d. LOCATION (City, town, or county) (State) <b>OKLAHOMA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co</b>				ADDRESS <b>517-11th St SE</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 9 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

03333

CERTIFICATE OF DEATH

03333

(M)

RELATION OF DECEASED

RELATION OF DECEASED

WASHINGTON

WASHINGTON AIR FORCE BASE 1 007

2301 12TH AVENUE SE

2 401 FORD HOSPITAL

TYNIAWA

NORTHMAN

LUTHER

HAROLD

17 SEPTEMBER 1950

CAUCASIAN

MALE

UNITED STATES

OKLAHOMA

US AIR FORCE

OFFICER

KATHRYN MARIE

104 - PRESENT AND IN - 1950 - 1951

YES

HEMORRHOIDAL DYSPLASIA

CHRONIC DEGENERATIVE LIVER DISEASE

2 FEBRUARY 52 6 FEBRUARY 52

6 FEBRUARY 52

*[Handwritten signature]*

WASHINGTON AIR FORCE BASE, WASHINGTON

WASHINGTON AIR FORCE BASE

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1, 2, and 3 to the funeral director, and Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
02247 02230											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 13 Kennelworth				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital						d. STREET ADDRESS 1708 Kennelworth Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sidney Middle Horsey Last						4. DATE OF DEATH February 24, 19 62		Month		Day Year	
5. SEX Male		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 29, 1932		9. AGE (In years last birthday) 30 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Property Clerk		10b. KIND OF BUSINESS Hospital		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Sidney Stevenson						14. MOTHER'S MAIDEN NAME Frances Horsey					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes Korean				16. SOCIAL SECURITY NO. 217-28-3381		17. INFORMANT Howard Horsey (Same as two)				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock & Hemorrhage DUE TO (b) Stab wound of chest Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stabbed in chest during an altercation							
20c. TIME OF INJURY Month, Day, Year 1:28 p.m. 2/24/62		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Kennelworth P. G.		(County)		(State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/24/62			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF Feb 30		22c. NAME OF CEMETERY OR CREMATORY MT. PEAR		22d. LOCATION (City, town, or country) Marion	
23. FUNERAL DIRECTOR ADDRESS Anthony E. Ward Crisfield Md.						24a. REC'D BY REGISTRAR DATE 5 '62		24b. REGISTRAR'S SIGNATURE L. E. Evans			

1917

157-6100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02248

02231

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>70 College Park</b> d. STREET ADDRESS <b>9027 49th Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Herman R. Hunt</b>			4. DATE OF DEATH Month Day Year <b>February 19 1962</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>2-26-78</b>		9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Government</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Mass.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Josiah A. Hunt</b>			
14. MOTHER'S MAIDEN NAME <b>Julia Reynolds</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Mrs. Cora G. Hunt Same as #2 (Wife)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peripheral Vascular Collapse</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Mesenteric Thrombosis, Acute</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>12 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1955</b> to <b>Feb 19 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb 19 1962</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>William A. Donat</b> M.D.		22b. DATE SIGNED <b>2/19/62</b>		22c. PHYSICIAN'S NAME (Type) <b>William A. Donat</b>	
22d. ADDRESS <b>3503 Penny St Mt Rainier Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/22/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	
23d. LOCATION (City, town or county) <b>Colmar Manor,</b>		(State) <b>Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 23 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

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## CERTIFICATE OF DEATH

Reg. Dist. No. 02232

02249

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>		c. LENGTH OF STAY IN TB <u>57 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4019-36<sup>th</sup> Street</u>		d. STREET ADDRESS <u>4019-36<sup>th</sup> Street</u>	
3. NAME OF DECEASED (Type or print) <u>Josephine (NMI) Hutchinson</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>15</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>17 Oct. 1870</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hotel worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	11. BIRTHPLACE (State or foreign country) <u>Va.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>James G. Martin</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Catharine Lumsden</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>No</u>		INFORMANT Address <u>Margaret Bothome Hazel</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>433.0</u> DUE TO <u>cardiac arrest from cachexia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>and myocardial insufficiency of</u> (c) <u>generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1957</u> , 19 <u>62</u> to <u>15 Feb</u> , 19 <u>62</u> that I last saw the deceased alive on <u>12 Feb</u> , 19 <u>62</u> and that death occurred at <u>4:30 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas E. Mattingly, M.D.</u>		ADDRESS (Street, city or town, state) <u>2200 Rhode Is. Ave. N.E.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Thomas E. Mattingly, M.D.</u>		<u>Wash. 18, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/17/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malley's Funeral Home Inc.</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 19 '62</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1935

CERTIFICATE OF DEATH

1935



*[Faint, mostly illegible text, likely a death certificate form with fields for name, date, and cause of death.]*



88320

88320

(M)

Handwritten notes at the top of the page, including the word "Handwritten" and other illegible text.

Handwritten notes in the middle section, including the word "Handwritten" and other illegible text.

(T)

Handwritten notes in the lower middle section, including the word "Handwritten" and other illegible text.

Handwritten notes at the bottom of the page, including the word "Handwritten" and other illegible text.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02234

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>2 hours</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>31 Deanwood Park</b> d. STREET ADDRESS <b>5216 Maple Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Daisy Jackson</b>		4. DATE OF DEATH Month Day Year <b>February 27, 19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1908</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	9. AGE (In years last birthday) <b>53 yrs.</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jim Smith</b>		14. MOTHER'S MAIDEN NAME <b>Mary unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>George Jackson, same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebravascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (c) <b>Cardiovascular renal disease</b> DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>2/28/62</b>			
ACTUAL SIGNATURE <b>James I. Boyd</b> EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>3-3-62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Nat Harmony</b>	22d. LOCATION (City, town, or country) (State) <b>Highland Pk. Md</b>
23. FUNERAL DIRECTOR ADDRESS <b>Nanny Washington Sor 4925 Union Pk</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 6 '62</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>

02533

Department of State

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02533

JAMES I. FOX, N.Y.

James I. Fox, N.Y.

James I. Fox, N.Y.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

2

2

VS. A15ME  
5M 9/60

MD  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02252 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02235

1. PLACE OF DEATH a. COUNTY Prince George's				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 27 Capitol Heights			
c. LENGTH OF STAY IN 1b D.O.A.				d. STREET ADDRESS 6117 Kingston Road			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Louis Edward Jarboe				4. DATE OF DEATH Month Day Year Feb. 8 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 12, 1910 51 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handler		10b. KIND OF BUSINESS OR INDUSTRY Railway Express		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benjamin E. Jarboe				14. MOTHER'S MAIDEN NAME Margret Lena Heisler			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO. James J. Jarboe, 6901 Standish Drive Md.			
17. INFORMANT Address Radiant Valley, James J. Jarboe, 6901 Standish Drive Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd MD.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd MD.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, or other disposition (Specify) Burial				22b. DATE THEREOF Feb. 12, 1962			
22c. NAME OF CEMETERY Washington National				22d. LOCATION (City, town, or country) (State) Suitland, Maryland.			
23. FUNERAL DIRECTOR W. W. CHAMBERS CO., Riverdale, Md.				24a. REC'D BY REGISTRAR DATE FEB 13 '62			
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

DATE SIGNED  
2/8/62



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02253

Items 7, 8, 9, 10a, 11, 12, 13 &amp; 14 Film G307 2/15/62 iwk

02237

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Florence Johnson</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>3</b> Year <b>19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>XX Oct. 15, 1880</b>
9. AGE (In years last birthday) <b>81 yrs.</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Fletcher</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hall</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mary Hall</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>570.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Intestinal Obstruction</b> (a), stating the underlying cause last. DUE TO (c) <b>Volvulus of Cecum</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 Days</b> <b>10 Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Postoperative Laparotomy, Reduction of Volvulus and Cecostomy</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>1/30</b> to <b>2/3</b> , 19 <b>62</b> that (we) last saw the deceased alive on <b>2/3</b> , 19 <b>62</b> , and that death occurred at <b>4.10 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Wm. A. Holbrook</b>		22b. DATE SIGNED <b>2/5/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. William A. Holbrook</b>		22d. ADDRESS <b>4500 College Avenue, College Park, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-7-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hammony Park</b>		23d. LOCATION (City, town or county) (State) <b>Sherriff Rd. &amp; Palmer Hwy. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James W. Edmonson</b>		25. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
ADDRESS <b>908 6th St. N.W.</b>		25a. REC'D BY REGISTRAR <b>FEB 9 '62</b>	

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02254 CERTIFICATE OF DEATH 022381									
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE D. C. b. COUNTY -				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)			c. LENGTH OF STAY in lb 1 yr., 5 mos. and 26 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X 3			d. STREET ADDRESS D.C. Village	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital					a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Robert Middle - Last Johnson					4. DATE OF DEATH Month 2 Day 12 Year 19 62				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH ? ? 1908		9. AGE (In years last birthday) yrs. 53	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown (employed)		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (County & State, or foreign country) S.C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Johnson				14. MOTHER'S MAIDEN NAME Lennie ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unknown (lost)		17. INFORMANT Decedent			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Syphilitic aortitis with aortic insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Cerebrovascular accident (1951) with residual left hemiparalysis; generalized atherosclerosis								INTERVAL BETWEEN ONSET AND DEATH unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Huntsville		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/17/1960 to 2/12/1962 that (I) (we) last saw the deceased alive on 2/12/1962, and that death occurred at 10:10 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Moe Weiss, M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/12/62		
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.					22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-17-1962		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park			23d. LOCATION (City, town or county) (State) Huntsville, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Malvan. schey Inc. 424 R St N.W.					25a. REC'D BY REGISTRAR DATE FEB 19 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Himes		

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*Handwritten signature*

Partial 2-12-1962 Henry Memorial Park, Hightsville, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
02255					02239							
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)							
a. COUNTY Prince Georges MARYLAND					e. STATE D. C. b. COUNTY							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital					d. STREET ADDRESS 428 E. St., N.W.							
3. NAME OF DECEASED (Type or print) Willie Johnson					4. DATE OF DEATH 2 23 19 62							
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1903?		9. AGE (In years last birthday) 58? yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night-watchman					10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (County & State, or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ?					14. MOTHER'S MAIDEN NAME ?							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown					16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Casualty Hospital			Address Washington, D.C.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]										INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Intracerebral hemorrhage with right hemiparalysis										3 days		
443X DUE TO												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO												
Hypertensive cardiovascular disease										unknown		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Recurrent thrombosis of left middle cerebral artery												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1B.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 12/8/1961, to 2/23/1962, that (I) (we) last saw the deceased alive on 2/23/1962, and that death occurred at 11:05 A.M. from the causes and on the date stated above.												
22a. SIGNATURE Moe Weiss					M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/23/62			
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.					22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2-27-1962		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park			23d. LOCATION (City, town or county) (State) Huntsville, Md.				
24. FUNERAL DIRECTOR'S SIGNATURE Melvan-Schey Inc.					ADDRESS 4249 St NW.		25a. REC'D BY REGISTRAR DATE FEB 26 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thoms			

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Butaville, Mo.

Barney Memorial Park

2-27-1902

Barney Memorial Park

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, page 1, 2, and 3 to the funeral director, page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>02256</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>02240</div> </div> </div> <div> <div> <div> <div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> </div> <div> <div>2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</div> <div>a. STATE</div> </div> </div> <div> <div> <div>3. NAME OF DECEASED</div> <div>(Type or print)</div> </div> <div> <div>4. DATE OF DEATH</div> <div>Month</div> <div>Day</div> <div>Year</div> </div> </div> </div>													
<div> <div>Prince George's</div> <div>MARYLAND</div> </div>				<div> <div>Maryland</div> <div>Prince George's</div> </div>									
<div> <div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Beltsville</div> </div>				<div> <div>c. LENGTH OF STAY IN 1b</div> <div>47</div> </div>				<div> <div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>74 Beltsville</div> </div>					
<div> <div>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</div> <div>5402 O'Dell Road</div> </div>				<div> <div>d. STREET ADDRESS</div> <div>1 5402 O'Dell Road</div> </div>				<div> <div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div>					
<div> <div>3. NAME OF DECEASED</div> <div>(Type or print)</div> </div>				<div> <div>4. DATE OF DEATH</div> <div>February</div> <div>26</div> <div>19</div> <div>62</div> </div>									
<div>5. SEX</div> <div>Female</div>		<div>6. COLOR OR RACE</div> <div>Colored</div>		<div>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<div>8. DATE OF BIRTH</div> <div>July 20, 1893</div>		<div>9. AGE (In years last birthday)</div> <div>68 yrs.</div>		<div>IF UNDER 1 YEAR</div> <div>Months</div> <div>Days</div>		<div>IF UNDER 24 HRS.</div> <div>Hours</div> <div>Min.</div>	
<div> <div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Housewife</div> </div>				<div> <div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>Own home</div> </div>				<div> <div>11. BIRTHPLACE (State or foreign country)</div> <div>Virginia</div> </div>				<div> <div>12. CITIZEN OF WHAT COUNTRY?</div> <div>U. S. A.</div> </div>	
<div> <div>13. FATHER'S NAME</div> <div>Morton Brown</div> </div>				<div> <div>14. MOTHER'S MAIDEN NAME</div> <div>Virginia</div> </div>									
<div> <div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)</div> <div>no</div> </div>				<div> <div>16. SOCIAL SECURITY NO.</div> </div>		<div> <div>17. INFORMANT</div> <div>Douglas William King, same as # 2</div> </div>							
<div> <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>981X HEMORRHAGE AND Shock</div> <div>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b)</div> <div>Gunshot wound of chest</div> <div>(a), stating the underlying cause last.</div> <div>DUE TO (c)</div> </div>												<div> <div>INTERVAL BETWEEN ONSET AND DEATH</div> </div>	
<div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</div> </div>												<div> <div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div> </div>	
<div> <div>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</div> </div>				<div> <div>20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)</div> <div>Shot during an altercation in her home</div> </div>									
<div> <div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>2/26/ 19 62</div> </div>				<div> <div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/></div> </div>		<div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div>Home</div> </div>		<div> <div>20f. (City or town)</div> <div>Beltsville</div> </div>		<div> <div>(County)</div> <div>P.G.</div> </div>		<div> <div>(State)</div> <div>Md</div> </div>	
<div> <div>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:</div> <div>Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/></div> </div>													
<div> <div>ACTUAL SIGNATURE</div> <div>James I. Boyd</div> </div>				<div> <div>M.D.</div> <div>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></div> </div>				<div> <div>DATE SIGNED</div> <div>2/26/62</div> </div>					
<div> <div>EXAMINER'S NAME (Type)</div> <div>James I. Boyd</div> </div>				<div> <div>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></div> </div>				<div> <div>Address (Street, city, town, or county)</div> </div>					
<div> <div>22a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>3-3-62</div> </div>				<div> <div>22b. DATE THEREOF</div> </div>		<div> <div>22c. NAME OF CEMETERY OR CREMATORY</div> <div>Warrenton Ave.</div> </div>		<div> <div>22d. LOCATION (City, town, or country)</div> <div>Warrenton Virginia</div> </div>		<div> <div>(State)</div> </div>			
<div> <div>23. FUNERAL DIRECTOR</div> <div>ADDRESS</div> <div>Henry S. Washington &amp; Son 4925 Decade Ave</div> </div>				<div> <div>24a. REC'D BY REGISTRAR</div> <div>DATE</div> <div>MAR 1 '62</div> </div>		<div> <div>24b. REGISTRAR'S SIGNATURE</div> <div>Arthur L. Hanks</div> </div>							



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02257

02241

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Pr. Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 58 Hyattsville			
c. LENGTH OF STAY IN 1b D. O. A.				d. STREET ADDRESS 1 6903 23rd Place			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ARTHUR JAMES KRAUSE				4. DATE OF DEATH Month Day Year Feb. 2 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 4, 1875	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Plumber		11. BIRTHPLACE (State or foreign country) Wash. D. C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 17. INFORMANT Address Wash. D. C. Frank J. Sheahan 818 Randolph St., NW			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2-3-62 Address (Street, city, town, or county)							
ACTUAL SIGNATURE James I. Boyd		M.D.					
EXAMINER'S NAME (Type) James I. Boyd							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-5-62		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		22d. LOCATION (City, town, or country) (State) BLADENSBURG MD.	
23. FUNERAL DIRECTOR ADDRESS HANLON FUNERAL HOME - WASH. D. C.				24e. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	
				DATE FEB 8 '62			

11520

11520



Original 2-2-62 Ft. Lincoln Gen. 644-1000-100  
Frontier Avenue - West D.C.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2

VS. A15ME  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02258

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02242

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>35 Landover</b> d. STREET ADDRESS <b>Ardwick Road Rt #1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mable Blair Lampkin</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>5</b> Year <b>1962</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug 23, 1901</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		9. AGE (in years last birthday) <b>60</b> yrs.		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Henry Blair</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
16. SOCIAL SECURITY NO. <b>Redvers Lampkin Same as #2</b>				17. INFORMANT <b>Redvers Lampkin Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> 416X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Rheumatic heart disease</b> (c) DUE TO (e), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James I. Boyd, MD</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> February 6, 1962			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>2-9-1962</b>		22b. DATE THEREOF <b>2-9-1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Carver Mem. Park</b>		22d. LOCATION (City, town, or country) (State) <b>Md.</b>	
23. FUNERAL DIRECTOR <b>Frazier's Funeral Home, Inc. 389-R.D. Annapolis</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 9 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

1944

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0028

M



2-8-44 - 1st Lt. Charles W. Cook

Engineer General Home in 38-42-43

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02259

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02243

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Camp Springs		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 19 Camp Springs		d. STREET ADDRESS 5425 Branch Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Andrews Airbase Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William Dow Landreth				4. DATE OF DEATH February 2 19 62			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1958	9. AGE (In years last birthday) 3 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Hubert Landreth				14. MOTHER'S MAIDEN NAME Patsy L. Balderson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address William Hubert Landreth, same as # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute carbon monoxide poisoning (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of house that burned 20c. TIME OF INJURY Month, Day, Year 9:15 a.m. 2/2/19 62 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Camp Springs P.G. Md 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2/2/62 ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) James I. Boyd Address (Street, city, town, or county) 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 2-5-1962 22b. DATE THEREOF 2-5-1962 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill 22d. LOCATION (City, town, or country) (State) Suitland Md 23. FUNERAL DIRECTOR ADDRESS Robert A. Mattingly Wash DC 24a. REC'D BY REGISTRAR DATE FEB 5 '62 24b. REGISTRAR'S SIGNATURE Arthur S. Hunk							

03243

WEST VIRGINIA DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH AND EPIDEMIOLOGY  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

M

1. Name of Deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of Death: 10-15-1961

5. Place of Death: Home

6. Cause of Death: Myocardial Infarction

7. Manner of Death: Natural

8. Signature of Medical Examiner: [Signature]

9. Date of Examination: 10-15-1961

10. Location of Examination: Home

11. Name of Physician: Dr. J. Smith

12. Address of Physician: 123 Main St., City, W. Va.

13. Name of Coroner: Mr. J. Brown

14. Address of Coroner: 456 Oak St., City, W. Va.

15. Name of Registrar: Miss S. Green

16. Address of Registrar: 789 Elm St., City, W. Va.

17. Name of Burial Place: Greenwood Cemetery

18. Name of Burial: John Doe

19. Date of Burial: 10-16-1961

20. Name of Burial Place: Greenwood Cemetery

21. Name of Burial: John Doe

22. Date of Burial: 10-16-1961

23. Name of Burial Place: Greenwood Cemetery

24. Name of Burial: John Doe

25. Date of Burial: 10-16-1961

2 1 2  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME  
5M 9/60

202260 02244

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY <u>Prince George's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>36 Lanham</u>		
c. LENGTH OF STAY in lb <u>4 months</u>			d. STREET ADDRESS <u>5402 Whitfield Road</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5402 Whitfield Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Douglas Everett Larson</u>			4. DATE OF DEATH Month Day Year <u>Feb 18 1962</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 24 1924</u>	9. AGE (In years last birthday) <u>37</u> yrs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		
11. BIRTHPLACE (State or foreign country) <u>Montana</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Clarence Benjamin Larson</u>			14. MOTHER'S MAIDEN NAME <u>Louise Evelyn Kiewitz</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>WW II</u>			16. SOCIAL SECURITY NO. <u>501-28-2314</u>		
17. INFORMANT <u>Richard Eugene Larson, same as #2</u>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>974 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hanging</u> (c) DUE TO (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hanged self in closet of home</u>		
20c. TIME OF INJURY Month, Day, Year <u>11:50 a.m. 2-18 1962</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Lanham P. G. Md</u>	(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			Address (Street, city, town, or county) <u>2/18/62</u>		
22a. <del>REX</del> CREMATION, <del>XXXXX</del> (Specify)	22b. DATE THEREOF	22c. NAME OF <del>XXXX</del> OR CREMATORY	22d. LOCATION (City, town, or country) (State)		
<u>Cremation Feb. 23, 1962 Fort Lincoln Cemetery Bladensburg, Maryland.</u>					
23. FUNERAL DIRECTOR <u>W. W. Chambers &amp; Co. Riverdale, Md.</u>			24. REC'D BY REGISTRAR <u>Feb 23 '62</u>		
			25. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		



02261

## CERTIFICATE OF DEATH

Reg. Dist. No. 02245

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Md b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	c. LENGTH OF STAY IN 1b 10 months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 58 Hyattsville Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 17106 23rd Ave	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARY Middle C. Last LAWRENCE		4. DATE OF DEATH Month Feb Day 26 Year 1962	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 28, 1961
9. AGE (In years last birthday) yrs. 10		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Wash DC
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME RICHARD LAWRENCE	
14. MOTHER'S MAIDEN NAME ROSEMARY BLIGHT		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address FATHER	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition 756.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital obstruction of Biliary apparatus (c) Spontaneous Birth PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-28-1961, to 2-26-1962, that I last saw the deceased alive on 4-28-1961, and that death occurred at 10:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles A. Millwater M.D.		ADDRESS (Street, city or town, state) 2434-16th St NW. DATE SIGNED 2/26/62	
PHYSICIAN'S NAME (Type) CHARLES A MILLWATER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 27, 1962	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet	22d. LOCATION (City, town, or county) (State) Wash. DC
23. FUNERAL DIRECTOR'S SIGNATURE W. L. Latham 3603 14th St NW		24a. REC'D BY REGISTRAR DATE FEB 27 '62	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**1**  
**FOR STATE**  
**HEALTH DEPT.**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02246

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <span style="float: right;"><b>MARYLAND</b></span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) e. STATE <b>---</b> b. COUNTY <b>---</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adelphi</b>		c. LENGTH OF STAY IN lb <b>3 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Paint Branch Nursing Home</b> <b>2120 Powder Mill Road</b>		e. STREET ADDRESS <b>1725 17th Street, N.W.</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Josephine Weed LeButt</b>		<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>16</b> Year <b>19 62</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>MARCH 24, 1877</b>
<b>9. AGE</b> (In years last birthday) <b>84 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months <b>---</b> Days <b>---</b>	<b>IF UNDER 24 HRS.</b> Hours <b>---</b> Min. <b>---</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maine</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>JOHN WEED</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>MARY MAUDE WHEELER</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	
<b>17. INFORMANT</b> <b>6916 Granby Street</b> <b>Mrs Daurice Roman, Bethesda, Md.</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>442X Acute congestive heart failure</b> DUE TO (b) <b>Cardiovascular renal disease</b> DUE TO (c) <b>---</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>---</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>2Da. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>		<b>2Db. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of Injury In Part I or Part II of item 18.) <b>---</b>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>---</b> p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>---</b>	<b>20f. (City or town)</b> (County) (State) <b>---</b>
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <b>EXAMINER'S NAME</b> (Type) <b>James I. Boyd</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <b>2/16/62</b> <b>Address</b> (Street, city, town, or county) <b>---</b>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>	<b>22b. DATE THEREOF</b> <b>2/19/62</b>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Mount Hope</b>	<b>22d. LOCATION</b> (City, town, or country) (State) <b>North Attleboro, Mass.</b>
<b>23. FUNERAL DIRECTOR</b> <b>The S.H.Hines Co.-</b> <b>2901 14th St., N.W.</b> <b>Washington 9, D.C.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE FEB 19 '62</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Kraus</b>		<b>---</b>	

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Removal 12/1/55

The S. P. Hines Co.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
SM 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02263

02247

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		b. COUNTY	
Prince George's		Maryland		Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Cheverly		D.O.A.		47 Mount Rainier	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Prince George's General Hospital		3724 34th. Street			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		5. AGE (In years last birthday)	
First Middle Last		Month Day Year		IF UNDER 1 YEAR IF UNDER 24 HRS.	
Elmer Smith Little		February 27, 1962		70 yrs. Months Days Hours Min.	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Carpenter (Ret.)		Building		Westminister, Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Emanuel O. Little		Harriett Smith		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes		WWI		Yes, Unknown Mr. Arthur R. Wilcoxon, Mt. Rainier, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Ephosution			
177X DUE TO		metastases to bone			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO			
		(c) Carcenoma of Prostate			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
19				20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		2/28/62	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
JAMES I. BOYD, M.D.		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
Burial		3/2/62		St. John's Church	
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR	
Francis Gasch's Sons		Hyattsville, Maryland		24b. REGISTRAR'S SIGNATURE	
				24c. REC'D BY REGISTRAR	
				24d. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02264

## CERTIFICATE OF DEATH

02248

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (RURAL)</b> c. LENGTH OF STAY IN 1b <b>2 mo's, 5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>478-3</b> d. STREET ADDRESS <b>1305 - G. St., N.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>George R. Litz</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>February 25 1962</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>6-26-95</b>
<b>10e. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Cab driver</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Hacker</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Washington, D. C.</b>
<b>13. FATHER'S NAME</b> <b>George R. Litz</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Anna Ford</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes World War I</b>		<b>16. SOCIAL SECURITY NO.</b> <b>?</b>	
<b>17. INFORMANT</b> <b>Decedent</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma, right lung, with associated pneumonitis, metastases to left lung, lymph nodes and adrenals</b> DUE TO (b) <b>162.1</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Cirrhosis of the liver, post necrotic type, with portal hypertension (ascites, esophageal varices); paraplegia, cause unknown; tuberculosis, lymph nodes, right hilum.</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While Not While et work <input type="checkbox"/> et work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State) <b>11:02 P.M.</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from 12/20/61 to 2/25, 1962, that (I) (we) last saw the deceased alive on 2/25, 1962, and that death occurred at 11:02 P.M. from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Moe Weiss</b> M.D.		<b>22b. DATE SIGNED</b> <b>2/27/62</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Moe Weiss</b>		<b>22d. ADDRESS</b> <b>GLENNDALE HOSPITAL GLENNDALE, MD</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>3/1/1962</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Arlington, Va.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W.W. Chambers Co., Riverdale, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE MAR 5 '62</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Walter S. Kraus</b>			

08218

CERTIFICATE OF DEATH

08264

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Blair (HUMAN)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02265 CERTIFICATE OF DEATH 02249											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly						c. LENGTH OF STAY IN 1b 15 days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital						d. STREET ADDRESS 3104 Taylor Street					
3. NAME OF DECEASED (Type or print) Frances G. Loring						4. DATE OF DEATH Feb 27th 1962					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-27-87		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Iron Home				11. BIRTHPLACE (County & State, or foreign country) Joliet, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Myron Van Allen				14. MOTHER'S MAIDEN NAME Ellen Shields				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Florence E. Lo Jacoma daughter				Address 3852-Halley Ter S.E.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive Cardio Vascular Disease (a), stating the underlying cause last. DUE TO (c) 5 yrs INTERVAL BETWEEN ONSET AND DEATH 15 DAYS										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 1960 to Feb 21, 1962 that (I) (we) last saw the deceased alive on Feb 21, 1962, and that death occurred at 8:50 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Norman Donat Comear M.D.						ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 2/21/62		
22c. PHYSICIAN'S NAME (Type) NORMAN DONAT COMEAR						22d. ADDRESS 3503 Penny St Mt Rainier Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/24/62		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town or county) Colma Manor, Md.		23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home Inc.						ADDRESS Mt Rainier Maryland		DATE FEB 28 '62		Clifford E. Kraus	

02319

12085



Prince George's

Prince George's

Prince George's

St. James's

15 days

General

214 Taylor Street

Prince George's General Hospital

James E. Taylor  
2-27-87  
14

James E. Taylor  
2-27-87  
14

Hypertension (Arterial, systemic) severe stage  
Generalized tremor  
14 days

James E. Taylor  
2-27-87  
14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

02250

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) c. LENGTH OF STAY IN 1b 1 yr., 4 mo. & 12 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY - c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1509 N. Capitol St., N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Albert Middle - Last Marbury		4. DATE OF DEATH 2 2 4 19 62	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/16/1893
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown	11. BIRTHPLACE (County & State, or foreign country) Unknown
12. CITIZEN OF WHAT COUNTRY? -		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No -	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Decedent Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (a) Massive encephalomalacia, frontal parietal lobes, (left) (b) DUE TO Atherosclerotic occlusion of left middle cerebral artery (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive heart disease; renal disease, left, probably pyelonephritis; hyperstatic bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour e.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/23/19 60 to 2/4/19 62 that (I) (we) last saw the deceased alive on 2/4/19 62, and that death occurred at 2:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 2/4/1962	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/6/62	
23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial		23d. LOCATION (City, town or county) (State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Jas. Latney		25a. REC'D BY REGISTRAR 2-10-62	
ADDRESS 1700 Vermont Ave. Dist. Mt. Vernon, D.C.		25b. REGISTRAR'S SIGNATURE John P. Watson	

02330

02330



Handwritten signature or initials.

Handwritten notes at the bottom of the page, including the date 12/1/52 and other illegible text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN lb <b>15 HRS 37 MIN</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>US AIR FORCE HOSPITAL</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>GLASSMANOR</b> d. STREET ADDRESS <b>4904 NEPTUNE AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARIA CARILA MASLOG</b>						4. DATE OF DEATH Month Day Year <b>FEBRUARY 19 19 62</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>18 FEBRUARY 1962</b>		9. AGE (In years last birthday) yrs. <b>15</b>		IF UNDER 1 YEAR Months Days <b>15 37</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>				11. BIRTHPLACE (County & State, or foreign country) <b>PRINCE GEORGES, MARYLAND</b>			
13. FATHER'S NAME <b>VINCENTE MASLOG</b>				14. MOTHER'S MAIDEN NAME <b>EVELYN E LEMAY</b>				12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MEDICAL RECORDS</b>		Address <b>SAME AS ITEM #1</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Primary atelectasis</b> <b>762.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cause: Resp. / Infection</b> <b>Hypoxia + Anoxia</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2011 hrs 18 Feb 62 →</b> <b>1138 hrs A Feb 62 15' 27"</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>10:11 AM 19 Feb 19 62</b> to <b>1138 PM 19 Feb 19 62</b> , that (I) (the) last saw the deceased alive on <b>19 Feb 19 62</b> , and that death occurred at <b>1138 A</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Hestley D. Stepp</b> M.D.						22b. DATE SIGNED <b>13 Feb 62</b>					
22c. PHYSICIAN'S NAME (Type) <b>Stepp Hestley D. Capt USAF MC</b>						22d. ADDRESS <b>USA &amp; Hosp. Andrews AFB Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>2-23-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl Cem</b>		23d. LOCATION (City, town or county) <b>Ft Myer Va.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b>						ADDRESS <b>517-11-11 SE</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 23 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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PRINCE GEORGES  
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US AIR FORCE HOSPITAL

18 FEBRUARY 1962  
FEMALE  
MARIA CARLIA  
NABLOO  
FEBRUARY 19 1962

VINCENTE MARINO  
NONE  
BALTIMORE GEORGES, MARYLAND  
EVELYN E LEMAY  
UNITED STATES

NO  
NONE  
MEDICAL RECORDS  
SAME AS 17-11-61

27 FEB 1962

## CERTIFICATE OF DEATH

Reg. Dist. No. 02252

02268

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> <b>1516-2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Madison Manner</b>				d. STREET ADDRESS <b>556 Beacon Road</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>FANNIE Mc KINTZIE</b>				4. DATE OF DEATH Month Day Year <b>Feb. 4, 1962</b> <b>19</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 21, 1870</b>		9. AGE (In years last birthday) yrs. <b>91</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Thorpe</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Chadwell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>556 Beacon Road</b> <b>Miss Lillian Mc Kinzie, Silver Spring, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, Hypostatic</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b> <b>10 yrs.</b> <b>10 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Semility with senile agitation.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/28</b> , 19 <b>61</b> , to <b>2/4</b> , 19 <b>62</b> , that I last saw the deceased alive on <b>2/3</b> , 19 <b>62</b> , and that death occurred at <b>3:55</b> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Harold F. McCann</b> M.D.				ADDRESS (Street, city or town, state) <b>2355-16th St. NW</b>		DATE SIGNED <b>2/4/62</b>	
PHYSICIAN'S NAME (Type) <b>HAROLD F. MCCANN</b>				<b>Wash. 10, D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-7-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>		22d. LOCATION (City, lawn, or county) (State) <b>Ellicott City, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 6 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

10555

CERTIFICATE OF DEATH

10555

No. of Death 10555

Name of Deceased

Age

Sex

Color

Place of Birth

Date of Death

Time of Death

Place of Death

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of City Clerk

Signature of County Clerk

Signature of State Health Officer

Signature of Federal Health Officer

Signature of United States Surgeon General

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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02269

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02253

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CLINTON MD.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>12 CLINTON</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Southern MD. Hospital</b>		d. STREET ADDRESS <b>1 THRIFT RD. Box 312</b>	
3. NAME OF DECEASED (Type or print) <b>Lillian M. McLEAREN</b>		4. DATE OF DEATH Month <b>2</b> Day <b>23</b> Year <b>1962</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 18 1895</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY <b>AMERICAN</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>HUSBAND</b>		Address <b>THRIFT RD. Box 312</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EDEMA</b> DUE TO <b>416X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>RHEUMATIC HEART DISEASE</b> DUE TO (c) <b>10 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>1957, 1957 to 2, 1962</b> , that (I) (the hospital) saw the deceased alive on <b>2/23 1962</b> , and that death occurred at <b>8:45 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles F. Colao</b>		22b. DATE SIGNED <b>2/23/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES F. COLAO MD.</b>		22d. ADDRESS <b>BRANCH AVE CLINTON MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb 26-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>		23d. LOCATION (City, town or county) (State) <b>Southland, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>SIMMONS BROS.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 26 '62</b>	
ADDRESS <b>1661-600 Hwy 20, S.F.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02270

## CERTIFICATE OF DEATH

02254

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George County</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>14 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where decedent lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Naylor</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Clarence Middleton</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>Feb.</u> <u>26</u> <u>1962</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Color</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>5/29/93</u>		<b>9. AGE</b> (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Pr. George's Co. Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>					
<b>13. FATHER'S NAME</b> <u>George Middleton</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <u>Mamie Jones Aquasco, Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral Hemorrhage</u> (b) <u>Pulmonary Embolism</u> (c) <u>Arteriosclerosis Heart Diseases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)														<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>2-12</u> to <u>2-26</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2-26</u> , 19 <u>62</u> , and that death occurred at <u>11PM</u> from the causes and on the date stated above.															
<b>22a. SIGNATURE</b> <u>Dr. Robert Sasscer</u> M.D.										<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Dr. Robert Sasscer</u>										<b>22d. ADDRESS</b> <u>R.F.D. Box 2150, Upper Marlboro, Maryland</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>3/2/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Brooke Methodist</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Nottingham, Md.</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>George H. Nelson</u>										<b>ADDRESS</b> <u>Aquasco, Maryland</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DATE Feb 27/1962</u>		<b>25b. REGISTRAR'S SIGNATURE</b>	

VR A15 (4)  
15M 9/60

MAR 7 '62

Arthur S. House

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

02551

02551

M

former

George Middleton

known

known name (George) Mid.

*Robert*

D. Robert M. Reed

George Middleton

2/12

2/12

4 1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02271 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02255											
1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>						d. STREET ADDRESS <u>604 72nd. Place</u>					
3. NAME OF DECEASED (Type or print) <u>Betty May Miller</u>						4. DATE OF DEATH <u>February 12, 1962</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 8, 1930</u>		9. AGE (In years last birthday) <u>31</u> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Jenkins</u>						14. MOTHER'S MAIDEN NAME <u>Viola Thomason</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>Eugene Leroy Miller</u>					
17. INFORMANT <u>Same as #2</u>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>4-20-1</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>James I. Boyd</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>JAMES I. BOYD, M.D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2/14/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or country) <u>Arlington, Va.</u>		(State)	
23. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u>						ADDRESS <u>Hyattsville, Maryland</u>					
24a. REC'D BY REGISTRAR <u>FEB 13 '62</u>						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

05825

05825



Arlington

Arlington National

2/11/62

David

Francis Green's Sons, Hyattsville, Maryland

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02272

## CERTIFICATE OF DEATH

02256

Items 23 Film G307 2/26/62 iwk

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Adelphi</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Paint Branch Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Va</u> <span style="float: right;">b. COUNTY</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aslington Va 83X-3</u> d. STREET ADDRESS <u>2604 Key Blvd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Adelaide Ferman</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>2 17 1962</u> Month Day Year		<b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Oct 2 1888</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> yrs.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Amhst Va.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>9. AGE</b> (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.			
<b>13. FATHER'S NAME</b> <u>Clarence J Campbell</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Samah Ferman Parr</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>None</u> <b>17. INFORMANT</b> <u>Nursing Home records.</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>10-2-8</u> to <u>2-17</u>, 19<u>62</u>, that (I) (we) last saw the deceased alive on <u>2-16</u>, 19<u>62</u>, and that death occurred at <u>2300</u>, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>James H. [Signature]</u> M.D.		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <u>2-17-62</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>7717 Carroll Ave. Takoma Park Md.</u>		<b>22b. DATE SIGNED</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2/20/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Green Hill Cem.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>[Signature]</u>		<b>ADDRESS</b> <u>Del. Va.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>FEB 20 62</u> <b>DATE</b>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05250

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(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film 307 2-14-62 ans											
MAYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02273 Item 3, Telephone Call 2/6/62 jml											
02257											
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b> d. STREET ADDRESS <b>Route #1 Box 460</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>/Phyllis Farrys Morgal</b>						4. DATE OF DEATH Month Day Year <b>February 1 19 62</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-27-1870</b>		9. AGE (In years last birthday) <b>91 yrs.</b>		IF UNDER 1 YEAR Months Days <b>19 62</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer Farming</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>Waynesboro, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>John L. Morgal</b>						14. MOTHER'S MAIDEN NAME <b>Anna Miller</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <b>Joseph Elmer Morgal, son</b> <b>address above</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>C.H.F. (Chronic)</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerosis</b> causing the underlying cause last. (c) <b>Generalized A.S.D., Premort C.V.A.</b> <b>Cerebral vascular accident</b> INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b> <b>Unknown</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 2Da. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2Df. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>2/1/62</b> , 19 <b>62</b> , to <b>2/1/62</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>2/1/62</b> , 19 <b>62</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>R.F.D. Sasscer</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Dr. Robert B.G. Sasscer</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <b>R.F.D. Box 2150, Upper Marlboro, Md.</b> 22b. DATE SIGNED <b>3 Feb 62</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/5/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Md.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Malley's Funeral Home</b> <b>Inc.</b>						ADDRESS <b>Mt. Rainier Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 6 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Tuma</b>	

VR A15 (4)  
15M 9/60

(M)

1953

0253

Prince George's

Landward

Prince George's

Chamberly

1 day

Landover

Prince George's General Hospital

House 1

Box 450

Prince George's

Normal

February 1

Miss

11-21-1950

21

*Handwritten:* Robert L. McGehee, Jr.  
11-21-1950

*Handwritten:* C. V. S. (Singer)  
11-21-1950

11/62

*Handwritten:* McGehee

Dr. Robert L. McGehee

Box 450, Upper Landover, Md.

*Handwritten:* 11-21-1950  
11-21-1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# CENTRAL MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02274

02258

<b>1. PLACE OF DEATH</b> a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>US AIR FORCE HOSPITAL</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>VIRGINIA</b> b. COUNTY <b>FAIRFAX</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANNANDALE</b> d. STREET ADDRESS <b>305 CHAPEL DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>ARNOLD MULLINS</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>Feb 4 1962</b>	
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>CAUCASIAN</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>29 OCTOBER 1922</b>
<b>9. AGE</b> (In years last birthday) <b>39</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>PILOT</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>US AIR FORCE</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MOSSY BOTTOM, KENTUCKY</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>UNITED STATES</b>	
<b>13. FATHER'S NAME</b> <b>DOCK BILL MULLINS</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>ALKA WELLS</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>YES 1942-Present</b>		<b>16. SOCIAL SECURITY NO.</b> <b>406-12-4732</b>	
<b>17. INFORMANT</b> <b>PERSONNEL RECORDS</b>		Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MULTIPLE FRACTURES</b> 860 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HEMOTHORAX</b> (c) <b>PNEUMOTHORAX</b> INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b> <b>IMMEDIATE</b> <b>IMMEDIATE</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>AIRPLANE CRASH</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>FLIGHT LINE</b>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>2040 1962</b>		<b>20d. INJURY OCCURRED</b> While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>ANDREWS AIR FORCE BASE, MD</b>		<b>20f. (City or town) (County) (State)</b> <b>ANDREWS AIR FORCE BASE, MD</b>	
<b>21. I certify that (I) <del>XXXXXX</del> attended the deceased from 4 February 1962, to 4 February 1962, that (I) <del>XX</del> last saw the deceased alive on 4 February 1962, and that death occurred at 840P, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <i>Albert D Carilli</i> M.D.		<b>22b. DATE SIGNED</b> <b>4 Feb 62</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>ALBERT D CARILLI, Capt USAF MC</b>		<b>22d. ADDRESS</b> <b>USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>2/7/62</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>ARK NAT CEM</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>FORT MYER VA</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W W CHAMBERS CO SE WASH DC</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE FEB 8 '62</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Thayer</i>			



02327

02328

BRUCE COOPER

VIRGINIA

WILLIAM

ANDREWS AIR FORCE BASE

MURKIN

US AIR FORCE HOSPITAL

302 ORCHARD DRIVE

Alfred

Mulla

MALE

CAUCASIAN

29 OCTOBER 1952

PILOT

US AIR FORCE

MOOREY ROTARY, KENTUCKY

UNITED STATES

COCK HILL MILLING

ALMA WILLS

YES

1942-Present

406-11-4732

BRONKHORST RECORDS

INTERVIEW PARTICIPANT

INTERVIEW

INTERVIEW

AIRLINE CRASH

404-11-4732

FLIGHT LINE

4 February 52

4 February 52

Alfred

ALBERT B. DANIELL

Capit USAF MC USAF HOSPITAL, ANDREWS AIR FORCE BASE

2/1/52 AIRLIFT CAMP  
WILLIAM B. DANIELL (2nd) 2/1/52

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02275

## CERTIFICATE OF DEATH

02259

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Piscataway</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Piscataway</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>L.</b> Last <b>MUNSON</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>9,</b> Year <b>1962</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 2, 1891</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Francis Butler</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Newman</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Thomas Munson, 8730 Old Ft. Rd., Wash, D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> <b>4-93X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b></b> (a), stating the underlying cause last. DUE TO (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>ARTERIOSCLEROTIC CARDIAC DISEASE</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>a.m.</b> Month, Day, Year <b>19</b> p.m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 9th, 1962</b> to <b>Feb. 9th, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb. 9th, 1962</b> , and that death occurred at <b>3:30 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Paul Chen, M.D.</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb. 9th, 1962</b>		
22c. PHYSICIAN'S NAME (Type) <b>PAUL CHEN, M. D.</b>			22d. ADDRESS <b>ACCOKEEK, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-13-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St Marys</b>	23d. LOCATION (City, town or county) (State) <b>Piscataway, Maryland</b>				
24 FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Maryland</b>			ADDRESS <b></b>		25a. REC'D BY REGISTRAR DATE <b>FEB 14 '62</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hunt</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

02380

02380



*Handwritten signature or initials.*

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02275

02260

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN lb <b>46</b> <b>Brentwood</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>4412 38th Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Francis</b> Last <b>Nicholson</b>				4. DATE OF DEATH <b>February 19, 1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 7, 1878</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Food</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Andrew J. Nicholson</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Bartlett</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>578-09-6781</b>		17. INFORMANT <b>Robert Francis Nicholson, same as # 2</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				DATE SIGNED <b>2/19/62</b>			
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>2-22-62</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem.</b>				22d. LOCATION (City, town, or country) (State) <b>Bladensburg, Md</b>			
23. FUNERAL DIRECTOR <b>W.W. Chambers Co. Riverdale, Md</b>				24a. REC'D BY REGISTRAR <b>DATE FEB 21 '62</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kowale</b>							

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James Earl Ray

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James Earl Ray

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02277

## CERTIFICATE OF DEATH

02261

Item 8 Film G307 2/13/62 iwk

<b>1. PLACE OF DEATH</b> a. COUNTY Prince Geo. County MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b one month d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Geo. Gen. Hosp.				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Bladensburg d. STREET ADDRESS 1 4905 Taylor St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last Percy M. Norman		<b>4. DATE OF DEATH</b> Month Day Year 2 3 19 62		<b>5. SEX</b> Male			
<b>6. COLOR OR RACE</b> W		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> 6-5-95/ 1894			
<b>9. AGE</b> (In years last birthday) 67 yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Ret. Foreman		<b>11. BIRTHPLACE</b> (County & State, or foreign country) St. Elizabeth's Hosp. Maryland			
<b>12. CITIZEN OF WHAT COUNTRY?</b> U. S. A.		<b>13. FATHER'S NAME</b> Joseph H. Norman		<b>14. MOTHER'S MAIDEN NAME</b> Sarah Marshall			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) Yes WWI		<b>16. SOCIAL SECURITY NO.</b> (If available, give number and date of service)		<b>17. INFORMANT</b> Address Virginia M. Norman same as #2 (Wife)			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2 Cerebral Abscess. DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 1 hour			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) 1-4-62			
<b>20f. (City or town)</b> 2-3-62		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> 2-3-62 <b>to</b> 2-3-62 <b>19</b> , <b>that (I) (we) last saw the deceased alive on</b> 2-3-62 <b>19</b> , <b>and that death occurred at</b> 11:00 PM <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> Dr. Robert B.G. Sassoer M.D.				<b>22b. DATE SIGNED</b> 2-3-62			
<b>22c. PHYSICIAN'S NAME</b> (Type) Dr. Robert B.G. Sassoer				<b>22d. ADDRESS</b> R.F.D. Box 2150, Upper Marlboro, Md.			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) Burial		<b>23b. DATE THEREOF</b> 2/7/62		<b>23c. NAME OF CEMETERY OR CREMATORY</b> Ft. Lincoln			
<b>23d. LOCATION</b> (City, town or county) Colmar Manor,		<b>(State)</b> Md.		<b>25a. REC'D BY REGISTRAR</b> DATE FEB 8 '62			
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> Francis Gasch's Sons Hyattsville, Maryland				<b>25b. REGISTRAR'S SIGNATURE</b> Arthur L. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

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Ref. Foreman St. Elizabeth's Hospital, Maryland  
Joseph H. Norman  
Virginia M. Norman, same as 12 (Wife)

Francis Charles Bone, Hyattsville, Maryland  
David  
217162  
St. Lincoln  
Colonel Manor  
R. B. Bone 2162, Upper Marlboro, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02278

02262

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Suitland 23</u> c. LENGTH OF STAY IN lb <u>23 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suitland Nursing Home, Inc.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights 21</u> d. STREET ADDRESS <u>5012-26th Ave., S.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Harris Agnes Gertrude Norris</u>		<b>4. DATE OF DEATH</b> First Middle Last <u>2/18/62</u>		<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>10/24/1879</u>		<b>9. AGE</b> (In years) <u>82</u> <b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>St. Mary's, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Frank Brown</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Thompson</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b>			
<b>17. INFORMANT</b> <u>Mrs. Etta Weidman</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Atherosclerosis</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u> <u>hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Surgical amputation of leg for atherosclerosis</u>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1942</u> <b>19</b> <u>24</u> <b>18</b> <u>1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>2/15/62</u> <b>19</b> <u>62</u> <b>and that death occurred at</b> <u>2:15 P.M.</u> <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Wilbur H. Martin</u> <b>M.D.</b>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22b. DATE SIGNED</b> <u>2/19/62</u>							
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>WILBUR H. MARTIN M.D.</u>				<b>22d. ADDRESS</b> <u>106 Waltham St. N.E. Wash 2, D.C.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>2-21-1962</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>East Lincoln</u>			
<b>23d. LOCATION</b> (City, town or county) (State) <u>Prince George County Ind</u>											
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>D.A. Williams</u> <b>ADDRESS</b> <u>131-11th St. S.E.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>Arthur S. Thomas</u>				<b>25b. REGISTRAR'S SIGNATURE</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02279

## CERTIFICATE OF DEATH

02263

<b>1. PLACE OF DEATH</b> a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) c. LENGTH OF STAY IN 1b 1 month and 11 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE D. C. b. COUNTY - c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3 d. STREET ADDRESS 1230 N.H. Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) John - Oberleitner				<b>4. DATE OF DEATH</b> Month 2 Day 2 Year 19 62							
<b>5. SEX</b> Male		<b>6. COLOR OR RACE</b> white		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> 3/17/1887		<b>9. AGE</b> (In years last birthday) 74 yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Waiter <b>10b. KIND OF BUSINESS OR INDUSTRY</b> Fred Buckholtz Occidental Restaurant <b>11. BIRTHPLACE</b> (County & State, or foreign country) Austria <b>12. CITIZEN OF WHAT COUNTRY?</b> USA				<b>13. FATHER'S NAME</b> Gus Oberleitner <b>14. MOTHER'S MAIDEN NAME</b> Elizabeth ?							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) No <b>16. SOCIAL SECURITY NO.</b> Unknown <b>17. INFORMANT</b> decedent Address				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma, left lung, histological type undetermined. DUE TO (b) 1621 Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Post-irradiation fibrosis.				<b>INTERVAL BETWEEN ONSET AND DEATH</b> 6 months			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19		<b>20d. INJURY OCCURRED</b> While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from</b> 12/22/1961 <b>to</b> 2/2/1962, <b>that (I) (we) last saw the deceased alive on</b> 2/2/1962, <b>and that death occurred at</b> 10:30 A.M. <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> Moe Weiss <b>22c. PHYSICIAN'S NAME</b> (Type) Moe Weiss, M.D.				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input checked="" type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> Glenn Dale Hospital Glenn Dale, Md.		<b>22b. DATE SIGNED</b> 2/2/62					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)		<b>23b. DATE THEREOF</b> 2/6/62		<b>23c. NAME OF CEMETERY OR CREMATORY</b> WASHINGTON NAT. CEM.		<b>23d. LOCATION</b> (City, town or county) (State) SUITLAND, MD.					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> HYSONG F.H. Hysong Funeral Home 1300 N. St. N.W. J.M. Hysong & P. Insley 1300 N. St. N.W. 100 (WASHINGTON, D.C.)				<b>25a. REC'D BY REGISTRAR</b> DATE 3/2-66		<b>25b. REGISTRAR'S SIGNATURE</b> FEB 7 '62					

055530

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Mr. [unclear]

055530

055530

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02280

## CERTIFICATE OF DEATH

02264

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellville</b>		c. LENGTH OF STAY IN 1b <b>89 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>R. F. D. Forest Place</b>				d. STREET ADDRESS <b>R. F. D. Forest Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NANNIE</b> Middle <b>(NMI)</b> Last <b>Peach</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>23</b> Year <b>1962</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 13, 1872</b>	
9. AGE (In years last birthday) <b>89 yrs.</b>		IF UNDER 1 YEAR Months <b></b> Days <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Dr. John Peach</b>				14. MOTHER'S MAIDEN NAME <b>Bettie Wellford</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mr. John W. Heim Same as #2 Nephew</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Arteriosclerosis - severe</b> 334X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June, 1960</b> , to <b>23 Feb, 1962</b> , that (I) (we) last saw the deceased alive on <b>22 Feb, 1962</b> , and that death occurred at <b>12 A.M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert Sasscer</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Robert Sasscer M. D.</b>				22d. ADDRESS <b>Upper Marlboro, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/25/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Oak</b>		23d. LOCATION (City, town or county) (State) <b>Mitchellville Md.</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Francis Gasch's Sons</b>				ADDRESS <b>Hyattsville, Maryland</b>		25a. REC'D BY REGISTRAR <b>FEB 26 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Julius S. Kraus</b>			

VR A15 (4)  
15M 9/60

Francis Casch's Sons, Fayetteville, Maryland

Serial 3155/62 Mt. Oak

Robert Sasser, M.D.

Miss Elliott

*John W. Hahn*

12 Feb 1962

*John W. Hahn*

*McGowan*

Dr. John Parsh

Houseswife

Own Home

Maryland

U.S.A.

Belle Wellford

Mrs. John W. Hahn, same as 12 nephew

*27*

*Charles (Hahn) Parsh*

Female White Nov. 15, 1878 89

Nannie (NMI) Parsh

*74*

*31*

R.E.D. Forest Place

Maryland

80 years

Forest Place

Forest Place

Maryland

Forest Place

1888

1888

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1, 2, and 3 to the funeral director. Give Pages 1, 2, and 3 to the funeral director. Give Page 5 may be retained for your files. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02281 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02265

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Hattie Elmyra Pearson				4. DATE OF DEATH Month Day Year February 12, 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 25, 1883 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min. February 25, 1883 78 yrs.	
11. BIRTHPLACE (State or foreign country) North Carolina				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Vernon Taylor				14. MOTHER'S MAIDEN NAME Martha			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 574-28-7027			
17. INFORMANT Address East Columbia Pk. Landover Md Ellen Fort 7600 Spring Street				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 480x DUE TO Conditions, if any, which gave rise to immediate cause (b) Influenza (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2-15-1962			
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery				22d. LOCATION (City, town, or country) (State) Blacksburg, Maryland			
23. FUNERAL DIRECTOR W.W. Chambers Co, Riverdale, Maryland.				24a. REC'D BY REGISTRAR DATE FEB 19 '62			
				24b. REGISTRAR'S SIGNATURE Charles S. Kneass			

MEDICAL CERTIFICATION

0550





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02228

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IS born

Colfax, Ark

since George's General Hospital

Self-Confidence Street

Self-Confidence

Tennell

Robert

Miss

January 21, 1932

AS

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Prince George's, Md.

U.S.A.

Robert F. Tennell

Boy for Adams

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10202 Ballington Avenue, White Plains, N.Y.

Dr. William A. Christensen

Ballington

Ballington National

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1944/11/11

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02283

02267

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>26 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>30 Cedar Heights</b> d. STREET ADDRESS <b>6223 Lee Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Phynes</b> First Middle Last <b>Perry</b>				4. DATE OF DEATH Month Day Year <b>February 19 19 62</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-9-97</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Wash. D C</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Rose Perry 6223 Lee Pl. Cedar Hgts</b>			
17. INFORMATION				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>610x</b> DUE TO <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (b) <b>Bilateral Hydronephrosis and Hydroureter</b> (c) <b>Benign Prostatic Hypertrophy</b> stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>1-24 62 to 2-19 62</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1-24</b> , 19 <b>62</b> , to <b>2-19</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>2-19</b> , 19 <b>62</b> , and that death occurred at <b>11:55</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Ottavio Gelmi M.D.</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>A.M.</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Ottavio Gelmi</b>				22d. ADDRESS <b>1801 Eye St., N. W. Washington, D. C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>2-23-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Not Harmony</b>		23d. LOCATION (City, town or county) (State) <b>Highland Pk Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry S. Washington &amp; Son</b>				ADDRESS <b>4925 New Ave NE</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 26 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

5350



1. *Abstract*

7. *Journal of the American Medical Association*, 1990; 263: 1025-1027.

274 33

29/07/92

7-2-5

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8-10

23:11

1001 Eye St., Washington, D. C.

02284

## CERTIFICATE OF DEATH

Reg. Dist. No.

02268

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>		c. LENGTH OF STAY IN 1b <b>78 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R. F. D.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mabel</b> First <b>ELIZABETH</b> Middle <b>Phelps</b> Last		4. DATE OF DEATH Month <b>Feb</b> Day <b>4</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 10, 1880</b>
9. AGE (In years lost birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Bureau of Eng.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Warren Phelps</b>		14. MOTHER'S MAIDEN NAME <b>Capitola Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>7125 Addison St. (brother)</b>	
17. INFORMANT <b>Spencer W. Phelps Landover Hills, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral occlusion with acute myocardial infarction - minute</b> DUE TO <b>4-20-62</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> year (c) <b>Generalized arteriosclerosis</b> year PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Influenza - 1 week</b> DUE TO <b>4-8-62</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 2/3, 1962</b> to <b>2/4, 1962</b> , that I lost saw the deceased alive on <b>2/3, 1962</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. James Kurtz</b> M.D.		ADDRESS (Street, city or town, state) <b>R.F.D. Gamble Md</b> DATE SIGNED <b>2/4/62</b>	
PHYSICIAN'S NAME (Type) <b>H. James Kurtz + 2</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/7/62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Trinity Church</b>		22d. LOCATION (City, town, or county) (State) <b>Collington, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 7 '62</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

02281

CENTRAL CITY, N.C.

02288

James George

Maryland

James George

18 years

18 years

18 years

R. E. D.

R. E. D.

Female

ELIZABETH

Female White

Pop. 10, 1880

U. S. Government

Maryland

U. S. A.

William W. Green

Capitol Johnson

1125 Adams St. (over)

Senator W. Philip Canby

*[Faint, illegible handwritten text]*

*[Faint, illegible handwritten text]*

217-22

Holy Trinity Church

Collington

Francis G. Smith's Sons

Hyattsville, Md.

VR A15 (4)  
15M 9/60

02269

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN TB <b>2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>25 Bradbury Heights</b>	
f. STREET ADDRESS <b>5315 W Street</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Howard</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>28</b> Year <b>19 62</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>21 Mar. 1879</b>	
9. AGE (In years last birthday) <b>82 yrs.</b>		10. IF UNDER 1 YEAR Months <b>82</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		12. KIND OF BUSINESS OR INDUSTRY <b>School teacher</b>	
13. BIRTHPLACE (County & State, or foreign country) <b>Carthage, New York.</b>		14. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
15. FATHER'S NAME <b>Orin Phillips</b>		16. MOTHER'S MAIDEN NAME <b>Julia Manchester</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		18. SOCIAL SECURITY NO. <b>none.</b>	
19. INFORMANT <b>Loren W. Parker</b>		20. ADDRESS <b>5315 W St., Md.</b>	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>① Renal Failure (Uremia)</b> <b>177X</b> DUE TO (b) <b>② Carcinoma of the prostate gland.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>③ Bilateral Hydronephrosis &amp; nephrosis</b>		22. INTERVAL BETWEEN ONSET AND DEATH	
23. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		24. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		26. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
27. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		28. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
29. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		30. (City or town) (County) (State)	
31. I certify that (I) (this hospital) attended the deceased from <b>2-26</b> <b>1962</b> , to <b>2-28</b> <b>1962</b> that (I) (we) last saw the deceased alive on <b>2-28</b> <b>1962</b> , and that death occurred at <b>2,454 M</b> from the causes and on the date stated above		32. SIGNATURE <b>Harry N. Carlton</b> M.D.	
33. PHYSICIAN'S NAME (Type) <b>Dr. Harry N. Carlton</b>		34. ADDRESS <b>940 25th Street, N. W., Washington, D. C.</b>	
35. BURIAL CREMATION, REMOVAL (Specify) <b>3/2/62</b>		36. NAME OF CEMETERY OR CREMATORY <b>Hillside Cemetery,</b>	
37. DATE THEREOF <b>3/2/62</b>		38. LOCATION (City, town or county) (State) <b>Champion, New York.</b>	
39. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co.,</b>		40. ADDRESS <b>517 11th St., S.E.</b>	
41. REC'D BY REGISTRAR <b>W. W. Chambers Co.,</b>		42. REGISTRAR'S SIGNATURE <b>W. W. Chambers Co.,</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02286

Item 9 Film 0308 3/5/62 ink

02270

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b> c. LENGTH OF STAY IN 1b <b>7 yrs., 4 months, and 13 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>-</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>800 Rhode Island Ave., NW</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Newton W. Phillips</b>		4. DATE OF DEATH Month <b>2</b> Day <b>17</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/7/03</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stableman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stewarts Riding School</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Warren Phillips</b>		14. MOTHER'S MAIDEN NAME <b>Ira Huff</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>? -14-4375</b>	
17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction, acute with complete heart block</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Thrombosis, right coronary artery</b> DUE TO (c) <b>Atherosclerotic coronary artery disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Far advanced, pulmonary tuberculosis; pulmonary edema; right pleural effusion</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/1/54</b> to <b>2/17/62</b> that (I) (we) last saw the deceased alive on <b>2/17/19 62</b> , and that death occurred at <b>8:00 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Moe Weiss</b> M.D.		22b. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-24-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Amisville</b>		23d. LOCATION (City, town or county) (State) <b>Amisville, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Joyner</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 26 '62</b>	
ADDRESS <b>Warrenton, Va.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

02220

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Walt H. H. H.

1-1-1930

Handwritten notes at the bottom of the page, including the name "Walt H. H. H." and other illegible text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. 02271

02287

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Forestville</i>		c. LENGTH OF STAY IN 1b <i>3 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>21 Forestville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4008 - 82nd Ave.</i>				d. STREET ADDRESS <i>14008 - 82nd Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mary Frances PLOTT</i>				4. DATE OF DEATH <i>2</i> Month <i>7</i> Day <i>1962</i> Year			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>MAR. 18, 1884</i>		9. AGE (In years lost birthday) <i>77</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Rhode Island</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>JAMES T. SKUCE</i>				14. MOTHER'S MAIDEN NAME <i>MARY L. PIERCE</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>LNA Sweeney</i>		Address <i>4008-82nd Ave. Forestville, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Chest Metastasis</i> <i>199X</i> DUE TO <i>Sarcoma of back</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>6 months</i> (c)						INTERVAL BETWEEN ONSET AND DEATH <i>5 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Arteriosclerotic Cardiovascular Disease</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>April 20, 1958</i> to <i>Febr. 7, 1962</i> , that I lost saw the deceased olive on <i>Febr. 4, 1962</i> , and that death occurred at <i>10 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Peter Duhus</i>				ADDRESS (Street, city or town, state) <i>6124 Central Ave. Md.</i>			
PHYSICIAN'S NAME (Type) <i>PETER DUHUS</i>				DATE SIGNED <i>2-7-62</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-12-62</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Arlington Natl</i>		22d. LOCATION (City, town, or county) (State) <i>Arlington Va</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Semmers Bros.</i>				ADDRESS <i>1661 - Good Hope Rd SE WASH DC</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 9 '62</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Evans</i>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <b>JOHN J. BROWN</b>		2. SEX <b>MALE</b>		3. AGE <b>65</b>	
4. DATE OF DEATH <b>10-15-1918</b>		5. TIME OF DEATH <b>10:00 AM</b>		6. PLACE OF DEATH <b>HOME</b>	
7. CAUSE OF DEATH <b>HEART DISEASE</b>		8. DISEASE OR INJURY <b>HEART DISEASE</b>		9. MODE OF DEATH <b>NATURAL</b>	
10. SIGNATURE OF PHYSICIAN <b>J. H. BROWN</b>		11. SIGNATURE OF WITNESSES <b>J. H. BROWN</b>		12. SIGNATURE OF DECEASED <b>J. H. BROWN</b>	
13. SIGNATURE OF REGISTRAR <b>J. H. BROWN</b>		14. SIGNATURE OF CLERK <b>J. H. BROWN</b>		15. SIGNATURE OF JURY <b>J. H. BROWN</b>	
16. SIGNATURE OF JURY <b>J. H. BROWN</b>		17. SIGNATURE OF JURY <b>J. H. BROWN</b>		18. SIGNATURE OF JURY <b>J. H. BROWN</b>	
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70. SIGNATURE OF JURY <b>J. H. BROWN</b>		71. SIGNATURE OF JURY <b>J. H. BROWN</b>		72. SIGNATURE OF JURY <b>J. H. BROWN</b>	
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HEALTH DEPT.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 02288 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02272

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manor Park</u>		c. LENGTH OF STAY IN 1b <u>40 years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Maryland Park</u>		36	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6512 C Street</u>				d. STREET ADDRESS <u>6512 C Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Augusta</u> Last <u>Pohl</u>				4. DATE OF DEATH Month <u>7</u> Day <u>19</u> Year <u>1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 22, 1889</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u>12</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Clegg</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Harry Francis Pohl, same as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442</u> <u>Cardiovascular accident</u> DUE TO (b) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a.m.</u> Month, Day, Year <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>2-7-62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-10-1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		22d. LOCATION (City, town, or country) (State) <u>Blacksburg Md.</u>	
23. FUNERAL DIRECTOR <u>Lee Funeral Home - Wash. 2, D.C.</u>				24a. REC'D BY REGISTRAR <u>13 '62</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

Reg. Dist. No. 02273

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pro Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>				c. LENGTH OF STAY IN 1b <b>46 Brentwood, Md</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MADISON MANOR NURSING HOME 4420-39 st</b>				d. STREET ADDRESS <b>4420-39 st</b>			
3. NAME OF DECEASED (Type or print) First <b>ANTON</b> Middle <b>FREDERICK</b> Last <b>POHLMANN</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>6-</b> Year <b>1962</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug 4-1888</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.C. Transit</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			
13. FATHER'S NAME <b>Henry Pohlmann</b>				14. MOTHER'S MAIDEN NAME <b>Amelia Becker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>			
17. INFORMANT <b>Melvin E. Pohlmann</b>				Address <b>Brentwood Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>?</b> INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1962</b> to <b>FEB 6, 1962</b> , that I last saw the deceased alive on <b>1962</b> , and that death occurred at <b>1 A M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6600 Bellcrest Rd W Hyattsville Md</b> DATE SIGNED <b>2/6/62</b>							
ACTUAL SIGNATURE <b>Howard D. Cohn</b>				PHYSICIAN'S NAME (Type) <b>HOWARD D. COHN west Hyattsville Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb 9, 1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>			
24a. REC'D BY REGISTRAR DATE <b>FEB 9 '62</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

CERTIFICATE OF DEATH

2222

DATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. RACE <i>White</i>		5. PLACE OF BIRTH <i>USA</i>		6. DATE OF BIRTH <i>1910</i>		7. PLACE OF DEATH <i>Home</i>		8. DATE OF DEATH <i>1955</i>		9. TIME OF DEATH <i>10:00 AM</i>		10. CAUSE OF DEATH <i>Heart Disease</i>		11. MANNER OF DEATH <i>Natural</i>		12. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		13. SIGNATURE OF REGISTRAR <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>		19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>		25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>		31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF WITNESS <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>		37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>		41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>		43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF WITNESS <i>John Doe</i>		46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>		49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF WITNESS <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>		55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>		61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>		67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>		73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>		76. SIGNATURE OF WITNESS <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>		79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>		81. SIGNATURE OF WITNESS <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>		85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>		91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF WITNESS <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>		97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	
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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02290

02274

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>2 Hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Oxen Hill</b> d. STREET ADDRESS <b>2409 Oxen Run Apt. S</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mary A. Polk</b>		4. DATE OF DEATH Month Day Year <b>February 8 19 62</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-15-22</b>	9. AGE (in years last birthday) <b>40 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Daniel McCarthy</b>		14. MOTHER'S MAIDEN NAME <b>Mary (Last name unknown)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-22-1999</b>		17. INFORMANT <b>Douglas T. Polk,</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>451X</b> IMMEDIATE CAUSE (a) <b>Bronch pneumonia</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <b>2-8</b> , 1962 to <b>2-8</b> , 1962, that (I) (we) last saw the deceased alive on <b>2-8</b> , 1962, and that death occurred at <b>1:45</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>[Signature]</b>		22b. DATE M.D. <b>2-8-62</b>		22c. ADDRESS <b>P.G.G. Hospital</b>			
22c. PHYSICIAN'S NAME (Type) <b>[Signature]</b>		22d. ADDRESS <b>P.G.G. Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-12-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens Cem.</b>	23d. LOCATION (City, town or county) (State) <b>Arlington, Va.</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ives Funeral Home, 2847 Wilson Blvd. Arl., Va.</b> By: <b>C.M. [Signature]</b>			25a. REC'D BY REGISTRAR DATE <b>FEB 13 '62</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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James I. Thompson

701 Maple Gardens Co., Arlington, Va.

Approved by \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02291				CERTIFICATE OF DEATH				02275			
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 69 College Park					
c. LENGTH OF STAY IN 1b 24 days						d. STREET ADDRESS 9604 49th Ave.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Charles Kelly Powell						4. DATE OF DEATH Feb 10 19 62					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8 July 1891		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machanic		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (County & State, or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S. A.		IF UNDER 24 HRS. Hours Min.			
13. FATHER'S NAME C. C. Powell						14. MOTHER'S MAIDEN NAME Anna Steck					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16. SOCIAL SECURITY NO. 085-10-2361		17. INFORMANT Miss Verda Powell		119 Willoughby Road Fanwood, N. J.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42 0.0. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Gastros ulcers INTERVAL BETWEEN ONSET AND DEATH											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from 17 Jan 1962, to 10 Feb 1962 that (I) (we) last saw the deceased alive on 10 Feb 1962 and that death occurred at 12:50 A.M. from the causes and on the date stated above.											
22a. SIGNATURE William B Gunther M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) Dr. William B Gunther, M.D.						22d. ADDRESS 9812 49th Ave College Park., M.D.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 2/13/62		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City, town or county) Colmar Manor, Md.		(State)			
24 FUNERAL DIRECTOR'S SIGNATURE Gasch's Funeral home						25a. REC'D BY REGISTRAR DATE FEB 14 '62		25b. REGISTRAR'S SIGNATURE			

1011

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02292

## CERTIFICATE OF DEATH

Item 8 Film G308 3/6/62 mh

02276

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>P.G.</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>		d. STREET ADDRESS <i>General Delivery</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Elizabeth</i>		First <i>Elizabeth</i>		Middle <i>Powell</i>		Last <i>Powell</i>		4. DATE OF DEATH Month <i>2</i> Day <i>12</i> Year <i>1962</i>		5. SEX <i>F</i>		6. COLOR OR RACE <i>Negro</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7/3/1896</i>		9. AGE (In years last birthday) <i>66</i> yrs.		10. IF UNDER 1 YEAR Months <i>6</i> Days <i>6</i>		11. IF UNDER 24 HRS. Hours <i>6</i> Min. <i>6</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Anne Arundel Co., Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Daniel Thomas</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Williams</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>William Powell Laurel R. F. O.</i>		Address <i>Laurel</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PULMONARY EDEMA</i> DUE TO (b) <i>CONGESTIVE HEART FAILURE</i> DUE TO (c) <i>ARTERIOSCLEROTIC C. V. D.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>422.1</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>2-26</i> , 1962, to <i>2-27</i> , 1962, that (I) (we) last saw the deceased alive on <i>2-27</i> , 1962, and that death occurred at <i>9:30 A.M.</i> , from the causes and on the date stated above.		22a. SIGNATURE <i>Jeanne C. Bateman</i>		M.D. <i>Dr. Jeanne C. Bateman</i>		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3/3/62</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bacon's Chapel</i>		23d. LOCATION (City, town or county) <i>Anne Arundel Co. Md</i>		24. FUNERAL DIRECTOR'S SIGNATURE <i>Ridgely Solly</i>		25a. REC'D BY REGISTRAR <i>2 '62</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kram</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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02538

(M)

Feb 1

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Commenced

Great Migration

Wm. L. Wilson Forest Ranger

Wm. L. Wilson

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50-5

Dr. James J. ...

March 3/02 ...  
Michigan ...

M

99

VS. AISME  
5M 9/60

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>RFD 1653</b>	
3. NAME OF DECEASED (Type or print) <b>Carolyn Ravenell</b>		4. DATE OF DEATH <b>February 3 1962</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 8, 1953</b>	
9. AGE (In years last birthday) <b>8 yrs.</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		12. IF UNDER 24 HRS. Hours <b>19</b> Min. <b>62</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Juanita Ravenell</b>		14. MOTHER'S MAIDEN NAME <b>James Edward Quarles</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs Mary Mitchell</b>		18. ADDRESS <b>D.O. Welfare Department Washington, D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) <b>Bronchopneumonia</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		DATE SIGNED <b>February 3, 1962</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-9-1962</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial Park</b>		22d. LOCATION (City, town, or country) (State) <b>Huntsville, Md.</b>	
23. FUNERAL DIRECTOR <b>MALVAN &amp; SCHEY, INC. 424 "R" St., N. W.</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 9 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02294					02278				
<b>1. PLACE OF DEATH</b> a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> <b>3 DAYS</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>US AIR FORCE HOSPITAL</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b> d. STREET ADDRESS <b>6402 LANHAM WAY</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <b>JOSEPH IRVING REYNOLDS</b>			First Middle Last		<b>4. DATE OF DEATH</b> <b>FEBRUARY 5 19 62</b>		Month Day Year		
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>CAUCASIAN</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>1 FEBRUARY 1962</b>		<b>9. AGE</b> (In years last birthday) <b>3</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>3</b> Days <b>3</b>	<b>IF UNDER 24 HRS.</b> Hours <b>3</b> Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>NONE</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>NONE</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>PRINCE GEORGES, MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>UNITED STATES</b>		
<b>13. FATHER'S NAME</b> <b>WILLIAM ROBERT REYNOLDS</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>ELEANOR ROSE DEANGELIS</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>			<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>		<b>17. INFORMANT</b> <b>MEDICAL RECORDS</b>		<b>Address</b> <b>SAME AS ITEM #1</b>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>771.0</b> IMMEDIATE CAUSE (a) <b>Respiratory distress syndrome</b> DUE TO (b) <b>Placental dysfunction</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) <b>Hemorrhagic disease of newborn</b>							<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>75 hrs</b>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)</b>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that</b> (this hospital) attended the deceased from <b>1 Feb 1962</b> , to <b>5 Feb 1962</b> , that (I) saw the deceased alive on <b>5 Feb 1962</b> , and that death occurred <b>0006 AM</b> from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> <b>John A Moore</b> M.D.					<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>5 Feb 62</b>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>JOHN A MOORE, Major USAF MC</b>					<b>22d. ADDRESS</b> <b>USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD</b>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>			<b>23b. DATE THEREOF</b> <b>2/8/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>ARL NATIONAL</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>FORT MYER VA</b>		
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W.W. CHAMBERS Co WASH DC</b>					<b>25a. REC'D BY REGISTRAR</b> <b>FEB 9 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Thomas</b>		

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*[Faint bleed-through from reverse side]*

Arthur S. Krumm

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02210

02209



NAME	LAST	FIRST	MIDDLE
WILLIAM	JOHN	DAVID	WILLIAM
DATE	1910	10	10
AGE	21	10	10
SEX	MALE		
RELIGION	PROTESTANT		
EDUCATION	HIGH SCHOOL		
OCCUPATION	LABORER		
RESIDENCE	1000	10	10
CITY	CHICAGO		
STATE	ILLINOIS		
COUNTRY	U.S.A.		
DATE	1910	10	10
AGE	21	10	10
SEX	MALE		
RELIGION	PROTESTANT		
EDUCATION	HIGH SCHOOL		
OCCUPATION	LABORER		
RESIDENCE	1000	10	10
CITY	CHICAGO		
STATE	ILLINOIS		
COUNTRY	U.S.A.		

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RECORDS AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

02296

02280

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> ✓ b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> 47X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Forestville</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Forestville Nursing Home</b>		d. STREET ADDRESS <b>3359 Nichols Ave</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Elsie</b> First <b>Oega</b> Middle <b>RUSH</b> Last		4. DATE OF DEATH <b>February 8, 1962</b> Month <b>8</b> Day <b>1962</b> Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 28, 1891</b> 70 yrs.
9. AGE (In years last birthday) <b>70</b>		10. IF UNDER 1 YEAR: Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Keeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>(in Cleveland, Ohio)</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. of A.</b>	
13. FATHER'S NAME <b>Lee Calvert</b>		14. MOTHER'S MAIDEN NAME <b>Samantha Cain</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>234-09-1659</b>	
17. INFORMANT <b>Mrs. Mary C. HUDSON, Washington, D.C.</b> Address <b>3359 Nichols Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>471X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>—</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>—</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) <b>—</b> (County) <b>—</b> (State) <b>—</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 6, 1962</b> to <b>Feb. 8, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb. 8, 1962</b> , and that death occurred at <b>9 1/2</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Walcutt W. Gibson</b> M.D.		22b. DATE SIGNED <b>February 8, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Walcutt W. Gibson, M.D.</b>		22d. ADDRESS <b>4340 St. Barnabas Road, Washington 21, D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-12-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ROBERTS RIDGE CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>MOONSVILLE, W. VIRGINIA</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co. Rural, Maryland</b>		25a. REC'D BY REGISTRAR <b>FEB 13 '62</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles L. Finner</b>	

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CERTIFICATE OF DEATH

105-20

105-20



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 02297 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02281

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1, 2, and 3 to the funeral director, and Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>23 District Heights</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>1 District Heights Medical Center 7702 District Heights Parkway</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HENRY SHARDEN SCHWAMP</u>				4. DATE OF DEATH Month Day Year <u>February 7, 1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 15, 1961</u>	
9. AGE (In years last birthday) <u>7</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Child</u>		11. BIRTHPLACE (State or foreign country) <u>Cheverly, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Sharden H. Schwamp</u>				14. MOTHER'S MAIDEN NAME <u>Joanne Pritickies</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mr. Sharden H. Schwamp, Hgts. Parkway, Md.</u>				Address <u>7702 District</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>085</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Measles</u> (c) <u>Measles</u> (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				DATE SIGNED <u>February 7, 1962</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 10, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		22d. LOCATION (City, town, or country) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR ADDRESS <u>W. W. CHAMBERS CO. Riverdale, Md.</u>				24a. REC'D BY REGISTRAR   24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

2077181161



3301

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Med Exam Notified 2/12/62 3:30 PM - Released 2/12/62

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

02298

CERTIFICATE OF DEATH

02282

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mary land</b> b. COUNTY <b>Pr. Geo.</b>	
c. LENGTH OF STAY IN 1b <b>8 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>65 Riverdale</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>4714 Oliver Street</b>				d. STREET ADDRESS <b>4714 Oliver Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>ALEXANDER</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>8</b> Year <b>1962</b>		
First Middle Last <b>B. SECOR</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/2/78</b>		9. AGE (In years last birthday) <b>83</b>
			IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Clerk Govt.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Navy Dept.</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>J. Eugene Secor</b>			14. MOTHER'S MAIDEN NAME <b>Maria Kenny</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220347962A</b>		17. INFORMANT <b>Elsie L. Secor</b> Address <b>Same as # 2 (Wife)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ac Pulmonary Congestion.</b> DUE TO (b) <b>Arterio-sclerotic Heart Disease</b> DUE TO (c) <b>a decompensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
INTERVAL BETWEEN ONSET AND DEATH <b>30 MIN</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> to <b>Feb</b> 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>2/11</b> 19 <b>62</b> , and that death occurred at <b>3:30</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <b>W. L. Etienne</b>		22b. DATE SIGNED <b>2-8-62</b>		22c. PHYSICIAN'S NAME (Type) <b>W. L. ETIENNE</b>	
22d. ADDRESS <b>4712 Benning Rd College Park, Md</b>					
23a. BURIAL, CREMATION, Removal (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/12/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>	
23d. LOCATION (City, town, or county) (State) <b>Port Ewen New York</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 13 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>	

100

- [caption]

4. *Chrysomelids* (Coleoptera: Chrysomelidae) 19309

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02299 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02283											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Stafford ✓					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bowie				c. LENGTH OF STAY IN 1b Few Hours		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Stafford				83X-3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bowie Race Track						d. STREET ADDRESS Route 1 Box 81					
3. NAME OF DECEASED (Type or print) First Ashton Middle Shackelford Last						4. DATE OF DEATH February 13, 1962					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 16, 1888		9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman				10b. KIND OF BUSINESS OR INDUSTRY Streetcar				11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Strother Alexander Shackelford						14. MOTHER'S MAIDEN NAME Jeanette Mahoney N.W.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 578-10-7593		17. INFORMANT Walter Gordon Shackelford, Wash. D.C. Address 1432 Girard St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Acute CARDIAC FAILURE DUE TO (b) SEVERE, OCCLUSIVE CORONARY ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 2/13/62			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2-16-1962		22c. NAME OF CEMETERY OR CREMATORY Romath Church		22d. LOCATION (City, town, or country) Stafford		(State) Va	
23. FUNERAL DIRECTOR W.W. Chambers Co ADDRESS Riversdale, Md.						24a. REC'D BY REGISTRAR DATE FEB 19 '62		24b. REGISTRAR'S SIGNATURE Charles S. Hines			

05383

05383



05383

05383

1. PLACE OF DEATH a. COUNTY <b>Prince George's Landover Md</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pro George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>41 Landover Md</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6600 Old Landover Road</b>		d. STREET ADDRESS <b>6600 Old Landover Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Suzie R Shegogue</b>		First Middle Last		4. DATE OF DEATH Month Day Year <b>Feb 2, 1962</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 23, 1884</b>	9. AGE (In years lost birthday) <b>77</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>George M Henault</b>		14. MOTHER'S MAIDEN NAME <b>Annie Brooks</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Walter E Shegogue</b> Address <b>Landover, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Congestive Heart Failure</b> DUE TO (b) <b>arteriosclerosis coronary</b> DUE TO (c) <b>arteriosclerosis generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b> <b>10 yrs</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Large ventral hernia - Fibroid uterus</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> to <b>Jan 7, 1962</b> that (I) (we) last saw the deceased alive on <b>Jan 5, 1962</b> , and that death occurred at <b>330</b> A.M. from the causes and on the date stated above.					
22a. SIGNATURE <b>D. O. Watkins</b>		M. D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-3-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>DAYTON O WATKINS</b>		22d. ADDRESS <b>5318 Annapolis Rd Blenkensbury Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb 5, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	
23d. LOCATION (City, town, or county)		(State) <b>Colmar Manor, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 7 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kruse</b>					

053-4

CERTIFICATE OF DEATH

053-0

Lawrence, Mo.

Walter E. Shogren

name

no

Lawrence, Mo.

Walter E. Shogren

Lawrence, Mo.

Walter E. Shogren

Lawrence, Mo.

Walter E. Shogren

Lawrence, Mo.

Walter E. Shogren

Lawrence, Mo.

Walter E. Shogren

Lawrence, Mo.

Walter E. Shogren

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02301

## CERTIFICATE OF DEATH

02285

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY in lb <b>5 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edmonston</b>			
				f. STREET ADDRESS <b>5202 Decatur Street</b>			
3. NAME OF DECEASED (Type or print) <b>Mildred A Shotland</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>10</b> Year <b>1962</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>21 June 1902</b>	
9. AGE (In years last birthday) <b>59 yrs.</b>		10. IF UNDER 1 YEAR Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min. <b>59</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13. FATHER'S NAME <b>Frank Todd</b>				14. MOTHER'S MAIDEN NAME <b>Gertrude E. Pratt</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>Gladys E. Landis</b>				Address <b>1226 Clagett Dr., College Park, Md.</b> (Daughter)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>COR. PULMONALE</b> <b>443 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CHRONIC FIBROSIS WITH PULMONARY INSUFFICIENCY</b> DUE TO (c) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>FEB. 5, 1962</b> to <b>FEB. 10, 1962</b> , that (I) (we) last saw the deceased alive on <b>10 Feb 1962</b> , and that death occurred at <b>5:25 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>George Hageage</b> M.D. 22b. PHYSICIAN'S NAME (Type) <b>Dr. George Hageage., M.D.</b>				22c. ADDRESS <b>3717 38th Street Mt. Rainier., Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/12/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Basch's Funeral Home</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 13 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. Hance</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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10-10-1963

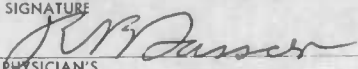

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02302

## CERTIFICATE OF DEATH

03686

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Brince Georges</b> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly,</b> c. LENGTH OF STAY IN lb <b>33 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Prince Georges</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlobofo, Md</b> d. STREET ADDRESS <b>Box 446</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Marie</b> Middle <b>Louise</b> Last <b>Showell</b>		<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>22</b> Year <b>19 62</b>					
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>1/17/96</b>	<b>9. AGE</b> (In years last birthday) <b>66</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Virginia</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>		
<b>13. FATHER'S NAME</b> <b>David Rudd</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Anderson</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>No</b>		<b>17. INFORMANT</b> Address <b>Box 292 Q-</b> <b>Mrs. Margaret Anderson-Rt 3-Easton, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulomary edema - arterioscleritio Ht. Disease</b> <b>340.3</b> DUE TO <b>Meningitis (organism undetermined)</b> Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> _____ (County) _____ (State) _____							
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>July</b> 19 <b>61</b> , to <b>22 Feb</b> 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>22 Feb</b> 19 <b>62</b> , and that death occurred at <b>8:30PM</b> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b>  <b>22c. PHYSICIAN'S NAME</b> (Type) <b>Dr. Robert B. G. Sassoer</b>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <b>R.F.D. Box 2150, Upper Marlboro, Md.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>2/25/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Trinity Newport Cem.</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Ritchie Bros. Fun'l Home</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE MAR 9 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-13-1962</i>	22c. NAME OF CEMETERY OR CREMATORY <i>MT. OLIVET CEM.</i>	22d. LOCATION (City, town, or county) <i>Wash., D.C.</i>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>JAMES T. Ryan, Inc. J.T. Ryan</i>		ADDRESS <i>317 Pa. Ave., SE</i>	24a. REC'D BY REGISTRAR DATE <i>Feb 13 '62</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kenna</i>

VS A15 (4)  
15M 10/57

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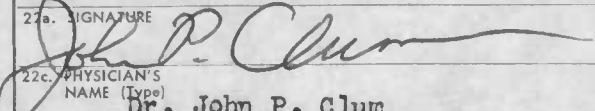
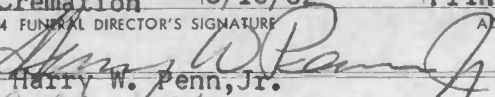
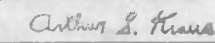
# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02304

03688

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>1 Hr 11 Min</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b> <span style="float: right;">COUNTY <b>Prince George's</b></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>36 Hyattsville</b> d. STREET ADDRESS <b>4913 78th A ve.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>Baby Boy</b> First Middle Last		<b>4. DATE OF DEATH</b> <b>Feb. 27</b> Month Day Year		<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>Feb. 27, 1962</b> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>9. AGE</b> (In years last birthday) <b>Feb. 27</b> yrs. Months Days <b>19 62</b> IF UNDER 1 YEAR Hours Min. <b>1 11</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>James Singer</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>Virginia Rae Winoman Singer</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>17. INFORMANT</b> <b>Mother</b> Address <b>Same</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>757-3</b> IMMEDIATE CAUSE (a) <b>CONGENITAL Absence of both kidneys + ureters</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> Hour a.m. p.m. <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Feb. 27</b> , <b>1962</b> <b>to</b> <b>Feb. 27</b> , <b>1962</b> <b>that (I) (we) last saw the deceased alive on</b> <b>Feb. 27</b> , <b>1962</b> , <b>and that death occurred at</b> <b>4:55 P.M.</b> <b>the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b>  <b>22c. PHYSICIAN'S NAME (Type)</b> <b>Dr. John P. Clum</b>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <b>6110 43rd Avenue, Hyattsville, Maryland</b>		<b>22b. DATE SIGNED</b> <b>2-27-62</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Cremation</b>		<b>23b. DATE THEREOF</b> <b>3/10/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Prince Geo. Gen. Hospital</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Cheverly, Maryland</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b>  <b>Harry W. Penn, Jr.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>MAR 15 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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(M)

02304

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Prince George

Prince George

Chaverry

Chaverry

Prince George

Prince George

Baby boy

Baby boy

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Other

Other

*[Faint handwritten text, possibly a signature or note]*

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1901

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1110 1st Avenue, Seattle, Wash.

1110 1st Avenue, Seattle, Wash.

Prince George

Prince George

1901

1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02305

CERTIFICATE OF DEATH

Reg. Dist. No. 02287

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HILLSIDE</u>	c. LENGTH OF STAY IN 1b <u>25 YRS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 HILLSIDE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1108-57<sup>th</sup> AVE.</u>		d. STREET ADDRESS <u>1108-57<sup>th</sup> AVE.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ETHEL</u> Middle <u>ELLSWORTH</u> Last <u>SMALL</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>25<sup>th</sup></u> Year <u>1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1893</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESTAURANT OPERATOR - SELF-EMPLOYED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASHINGTON, D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard L. Hunt</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude (?)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>ROBERT E. FRITZ</u>		Address <u>1108-57<sup>th</sup> AVE. HILLSIDE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>NW</u> , 19 <u>61</u> , to <u>Feb 25</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>Feb 24</u> , 19 <u>62</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Ernest E. Cornelius</u> M.D. <u>4400 BOWEN RD NW 2/25/62</u> PHYSICIAN'S NAME (Type) <u>ERNEST E. CORNELIUS</u> <u>WASHINGTON 19, DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Feb. 28, 1962</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS</u>		24a. REC'D BY REGISTRAR <u>Co. 517-11<sup>th</sup> ST SE. WASH DC</u>	24b. REGISTRAR'S SIGNATURE <u>Feb 28 '62</u> <u>William S. Kinne</u>



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02306

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02288

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Seabrook</b>				c. LENGTH OF STAY IN 1b <b>1 year</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>9515 Sheridan Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Shirley Annette Smith</b>				4. DATE OF DEATH Month <b>February</b> Day <b>26</b> Year <b>1962</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 14, 1934</b>	
9. AGE (In years last birthday) <b>27 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Leroy Jenkins</b>				14. MOTHER'S MAIDEN NAME <b>Mable XXXX Reid</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>			
17. INFORMANT <b>Joseph Shiro Smith, same as # 2</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>754.5</b> IMMEDIATE CAUSE (a) <b>Acute coronary INSUFFICIENCY</b> DUE TO (b) <b>Congenital defect of coronary ARTERIES</b> DUE TO (c) <b>and occlusive coronary ATHEROSCLEROSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Interval between ONSET AND DEATH							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>2/26/62</b> DATE SIGNED							
ACTUAL SIGNATURE <b>James I. Boyd</b> EXAMINER'S NAME (Type) <b>James I. Boyd</b>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/1/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		22d. LOCATION (City, town, or country) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>				24a. REC'D BY REGISTRAR <b>Hyattsville, Maryland</b>			
24b. REGISTRAR'S SIGNATURE <b>Charles L. Hanna</b>				DATE <b>2/1/62</b>			

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Francis G. Goss

Hyattsville, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02307

## CERTIFICATE OF DEATH

02289

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Georges</u> c. LENGTH OF STAY IN lb <u>29 days</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>30 Fairmont Heights</u> d. STREET ADDRESS <u>902 - 60th. Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>Wallace E. Smith</u>				<b>4. DATE OF DEATH</b> Month <u>2</u> Day <u>15</u> Year <u>1962</u>											
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Colored</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>7-15-90</u>		<b>9. AGE</b> (In years last birthday) <u>71</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Govt.</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>VA</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Dore Smith</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give word and date of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> Address <u>Wallace Smith Jr.</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>&amp; metastases</u> DUE TO (c) <u>  </u>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Unknown</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of Injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1-17-62</u> <b>to</b> <u>2-15-62</u> <b>, 19</b> <u>  </u> <b>, that (I) (we) last saw the deceased alive on</b> <u>2-15-19.62</u> <b>, and that death occurred at</b> <u>6:30 P.m.</u> <b>the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <u>R.B. Sasscer</u>				<b>22b. DATE SIGNED</b> <u>  </u>				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>							
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Dr. Robert B. G. Sasscer</u>				<b>22d. ADDRESS</b> <u>R.F.D. Box 2150, Upper Marlboro, Md.</u>											
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b>				<b>23b. DATE THEREOF</b> <u>2-19-62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Carver Men Park</u>		<b>23d. LOCATION (City, town or county)</b> <u>Murksh Md</u>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>H.S. W...</u>				<b>ADDRESS</b> <u>454920 Demora</u>				<b>25a. REC'D BY REGISTRAR</b> <u>FEB 20 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>					

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02308

## CERTIFICATE OF DEATH

02290

Item 8 Film G307 2/13/62 ink

### 1. PLACE OF DEATH

a. COUNTY

Prince Geo. County

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince Geo. Gen. Hosp.

### 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

e. STATE

Maryland

b. COUNTY

PG

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Laurel

d. STREET ADDRESS

320 Talbott Ave.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

### 3. NAME OF DECEASED (Type or print)

First

Elsie

Middle

V.

Last

Smithson

### 4. DATE OF DEATH

Month

2

Day

2

Year

19 62

### 5. SEX

F

### 6. COLOR OR RACE

White

### 7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

### 8. DATE OF BIRTH

Oct. 19-26-00

### 9. AGE (In years last birthday)

61 yrs.

### 10. IF UNDER 1 YEAR

Months Days

### 11. IF UNDER 24 HRS.

Hours Min.

### 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

NURSE

### 10b. KIND OF BUSINESS OR INDUSTRY

NURSING

### 11. BIRTHPLACE (County & State, or foreign country)

Pr. Geo. Co. Laurel Md

### 12. CITIZEN OF WHAT COUNTRY?

USA

### 13. FATHER'S NAME

Joseph F. Stevens

### 14. MOTHER'S MAIDEN NAME

Nettie M. Castle

### 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

no

### 16. SOCIAL SECURITY NO. (If yes give war or dates of service)

### 17. INFORMANT

Address

Margaret Pierpont Hyattsville Md.

### 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

#### PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Uremia

DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

(b)

Chronic Pyelonephritis

DUE TO

(c)

### INTERVAL BETWEEN ONSET AND DEATH

1 week

years

### PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Bronchopneumonia, Arteriosclerotic Heart Disease

### 19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

### 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

### 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

### 20c. TIME OF INJURY

Month, Day, Year  
Hour a.m.  
p.m. 19

### 20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

### 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

### 20f. (City or town)

### (County)

### (State)

21. I certify that (I) (this hospital) attended the deceased from 11-27-61, 19 to 2-2-62, 19, that (I) (we) last saw the deceased alive on 2-2-62, 19, and that death occurred at 8:50 PM the causes and on the date stated above.

### 22a. SIGNATURE

Dr. James Duke

M.D.

### ATTENDING PHYS.

☒

### MED. DIRECTOR

☐

### STAFF PHYS.

☐

### 22b. DATE SIGNED

2/3/62

### 22c. PHYSICIAN'S NAME (Type)

Drs. Gelmi/Duke

### 22d. ADDRESS

1801 Eye St., N. W. Wash. D.C.  
6607 Riverdale Rd., Riverdale, Md.

### 23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

### 23b. DATE THEREOF

2/5/62

### 23c. NAME OF CEMETERY OR CREMATORY

East Lincoln Cem.

### 23d. LOCATION (City, town or county)

Colman Manor, Md.

### 24. FUNERAL DIRECTOR'S SIGNATURE

Dr. Witt Donaldson

### ADDRESS

Laurel Md

### 25a. REC'D BY REGISTRAR

FEB 8 1962

### 25b. REGISTRAR'S SIGNATURE

Arthur S. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02309				Item 9 Film G307 2/19/62 iwk				02291			
1. PLACE OF DEATH a. COUNTY <b>Prince Geo. County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>177</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Geo. Gen. Hosp.</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>PG</b> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b> h. STREET ADDRESS <b>12422 Stone Haven Lane</b> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>ETHEL L. SPENCER</b>						4. DATE OF DEATH Month <b>2-10-62</b> Day <b>19</b> Year					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-5-1886</b>		9. AGE (In years last birthday) <b>75 7/8</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>16</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own Home</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John W Lovelace</b>						14. MOTHER'S MAIDEN NAME <b>Henrietta Cogements</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Irene Johnson</b>		Address <b>Charlotte County Virginia</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>Diabetes mellitus; Chronic cholecystitis;</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Chronic renal disease</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>1/28 1962 to 2/10 1962</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/10</b> to <b>2/10</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>2/10</b> , 19 <b>62</b> , and that death occurred at <b>1:45</b> P.M., from the causes and on the date stated above.											
22a. SIGNATURE <b>Julius Kauffman</b>						22b. DATE SIGNED <b>2/10/62</b>		22c. PHYSICIAN'S NAME (Type) <b>Julius Kauffman</b>			
22d. ADDRESS <b>5102 Annapolis Rd., Bladensburg, Md.</b>						22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Feb 13, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hebron Methodist</b>		23d. LOCATION (City, town or county) (State) <b>Charlotte County Va</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>						ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 13 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Knaus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health permit, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02310				CERTIFICATE OF DEATH				02292			
1. PLACE OF DEATH a. COUNTY <b>Prince George's County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>1 hr. 55 min</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colmar Manor</b> d. STREET ADDRESS <b>3414 - 42nd. St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Sharon LEE Spencer</b>			4. DATE OF DEATH Month <b>February</b> Day <b>23</b> Year <b>1962</b>			5. SEX <b>F</b>			6. COLOR OR RACE <b>W</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>2-19-62</b>			9. AGE (In years last birthday) Yrs. <b>5</b>			IF UNDER 1 YEAR Months <b>5</b> Days <b>5</b> Hours <b>5</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>			11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, D.C</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S</b>		
13. FATHER'S NAME <b>James Spencer</b>			14. MOTHER'S MAIDEN NAME <b>BARBARA ELLIOTT</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		
17. INFORMANT <b>JAMES HERBERT SPENCER</b>			Address <b>SAME AS #2</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Perforated Cecum</b> <b>5873</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Meconium Ileus</b> (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) <b>2-23-1962</b>			20g. (County) <b>2-23-1962</b>			20h. (State) <b>2-23-1962</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>2-23-1962</b> to <b>2-23-1962</b> that (I) (we) last saw the deceased alive on <b>2-23-1962</b> , and that death occurred at <b>7:10 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>David S. Clayman</b>						22b. DATE SIGNED <b>2/25/62</b>					
22c. PHYSICIAN'S NAME (Type) <b>DAVID S. CLAYMAN</b>						22d. ADDRESS <b>6311 Balto Ave - Riverdale, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>2-27-1962</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>			23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Chambers</b>						25a. REC'D BY REGISTRAR <b>1 '62</b>					
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>											

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NAME JAMES HERBERT SCHEWY  
WASHINGTON, D.C.  
BARRON STREET

NAME  
JAMES  
SCHEWY

2-27-1942  
DAVID S. CROFTMAN  
2-27-1942  
2-27-1942

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
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FOR STATE HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02311 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02293

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Pennsylvania b. COUNTY Fulton			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel D.O.A.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harrisonville 75X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Laurel General Hospital				d. STREET ADDRESS Star Route			
3. NAME OF DECEASED (Type or print) Gertrude Elizabeth Sponsler				4. DATE OF DEATH February 22 19 62			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25, 1903	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home			
11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Ellwood Leach				14. MOTHER'S MAIDEN NAME Anna Rice			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) none				17. INFORMANT Irene Julia Granata, Laura			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute pulmonary edema DUE TO (b) Congestive heart failure DUE TO (c) Coronary artery disease				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2/22/62			
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Feb 24, 1962		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or country) (State) Altoona, Penn.	
23. FUNERAL DIRECTOR De Witt Donaldson, Laurel, Md.				24a. REC'D BY REGISTRAR FEB 26 '62			
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02312

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02294

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>606 64th Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>Mildred</b> Last <b>Stanford</b>				4. DATE OF DEATH Month <b>February</b> Day <b>14</b> Year <b>19 62</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 26, 1890</b>		9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min. <b>71</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Eopley</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Mays</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Edwin Thomas Stanford</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO (b) <b>Cardiovascular renal disease</b> DUE TO (c) <b>Cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>2/14/62</b>							
ACTUAL SIGNATURE <b>James I. Boyd</b>		M.D. <b>JAMES I. BOYD, M.D.</b>					
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		Address (Street, city, town, or county) <b>Colmar Manor, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/16/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		22d. LOCATION (City, town, or country) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		24e. REC'D BY REGISTRAR <b>FEB 15 '62</b>	
				24b. REGISTRAR'S SIGNATURE <b>James I. Boyd</b>			

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Prince George's General Hospital  
606 6th Avenue  
Baltimore, Md.  
U.S.A.  
Sergeant  
Charles

Female  
White  
Status  
Married  
Stanford

Admission  
Date  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02313

## CERTIFICATE OF DEATH

Item 9 Film 0310 4/2/62 mh

02295

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Highland Park</b> d. STREET ADDRESS <b>1210 69th Place.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elizabeth Taylor</b>		4. DATE OF DEATH Month Day Year <b>Feb 28 19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 June 1923</b>
9. AGE (In years last birthday) <b>39 38</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Elms City, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Mary Boddie</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219 10 6301</b>	
17. INFORMANT <b>Walter Taylor</b>		Address <b>1210 69th Pl., Highland Pk., Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Unrelieved emboli</b> <b>705.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Pulm. edema</b> (a), stating the underlying cause last. (c) <b>hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-23</b> 19 <b>62</b> to <b>2-28</b> 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>2-28</b> 19 <b>62</b> , and that death occurred at <b>12:10AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Harry N. Carlton</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Harry N. Carlton</b>		22d. ADDRESS <b>940 25th Street, N.W., Washington, D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-3-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Harmony</b>		23d. LOCATION (City, town or county) (State) <b>Landover, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Myrtle G. Collins</b>		25a. REC'D BY REGISTRAR <b>4339 Hunt Pl., N.E.</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>		DATE <b>5 '62</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02314					02296						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission)						
a. COUNTY <b>Prince George's</b>					a. STATE <b>Maryland</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>					b. COUNTY <b>Prince George's</b>						
c. LENGTH OF STAY IN 1b <b>2 days</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>45 Brentwood</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>					d. STREET ADDRESS <b>4010 Allison Street</b>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED			First		Middle		Last		4. DATE OF DEATH		
			<b>Fenley</b>				<b>Taylor</b>		Month Day Year <b>February 23 19 62</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-9-82</b>		9. AGE (In years last birthday) <b>80 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>VA.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FENLEY TAYLOR</b>					14. MOTHER'S MAIDEN NAME <b>CATHERINE MASTERSON</b>					Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT <b>Hospital Record</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> 42801 DUE TO (b) <b>Myocardial Infarction secondary to occlusion of left anterior descending coronary artery</b> DUE TO (c) <b>Coronary Arteriosclerotic Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>years</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Washington, D.C.</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-21</b> to <b>2-23</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>2-23</b> 19 <b>62</b> , and that death occurred at <b>5:20 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Dr. Robert B. G. Sasser</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Robert B. G. Sasser</b>						22d. ADDRESS <b>R.F.D. Box 2150, Upper Marlboro, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>2.28.62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN CEMETERY</b>			23d. LOCATION (City, town or county) (State) <b>WASHINGTON, D.C.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert McKenzie</b>						ADDRESS <b>1820 9th St NW</b>		25a. REC'D BY REGISTRAR <b>FEB 28 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Carlton S. Hume</b>	
WASHINGTON, D.C.											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02315						02297					
1. PLACE OF DEATH a. COUNTY Prince Georges						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE D. C. b. COUNTY -					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital						d. STREET ADDRESS 3416 Warder St., N.W.					
3. NAME OF DECEASED (Type or print) Charles Taylor Terry, Jr.						4. DATE OF DEATH Month 2 Day 28 Year 1962					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1/3/1885		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days - -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (unknown)				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (County & State, or foreign country) Mississippi				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Terry, Sr.						14. MOTHER'S MAIDEN NAME Mary Campbell Terry					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Decedent					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Ruptured aneurysm, abdominal aorta 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Severe atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary tuberculosis; intestinal malignancy, historical, type and site undetermined										INTERVAL BETWEEN ONSET AND DEATH 1 day unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2/21/1962, to 2/28/1962, that (I) (we) last saw the deceased elive on 2/28/1962, and that death occurred at 4:15 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Moe Weiss						22b. DATE SIGNED 2/28/62					
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.						22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.					
23a. BURIAL, CREMATION, REMOVAL, (Specify)				23b. DATE THEREOF 3/3/62		23c. NAME OF CEMETERY OR CREMATORY Corner Memorial Funeral, Md				23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden						ADDRESS Reckville, Md		25a. REC'D BY REGISTRAR MAR 5 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

05315

CERTIFICATE OF DEATH

05315

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Robert L. Anderson  
of 312 - Corner  
Becknell, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02316

## CERTIFICATE OF DEATH

02298

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b <b>4 Hours</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>74 Beltsville</b> d. STREET ADDRESS <b>10622 Molcolgra Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <b>George M. Thomas</b>			<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>21</b> Year <b>1962</b>		
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Colored</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>April 20, 1881</b>	<b>9. AGE</b> (In years) <b>80</b> <b>80</b> <b>80</b> (In days) <b>0</b> <b>0</b> <b>0</b> yrs. Months Days Hours Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Maryland</b>			<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>U. S. A.</b>		
<b>13. FATHER'S NAME</b> <b>George M. Thomas</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Angeline ?</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>(If yes give year or dates of service)</b>			<b>16. SOCIAL SECURITY NO.</b>		
<b>17. INFORMANT</b> <b>Olivia Gross: same as item 2:</b>			<b>Address</b>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.0</b> DUE TO <b>Pulmonary em. &amp; edema</b> <b>420.0</b> DUE TO <b>Arteriosclerotic Bk de. cano</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.					<b>INTERVAL BETWEEN ONSET AND DEATH</b>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)		
<b>20c. TIME OF INJURY</b> Hour <b>19</b> e.m. p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>2-21</b> , <b>1962</b> , to <b>2-21</b> , <b>1962</b> that (I) (we) last saw the deceased alive on <b>2-21</b> , <b>1962</b> , and that death occurred at <b>2:30</b> , from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <b>Jeanne C. Bateman</b>			<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>	<b>22b. DATE SIGNED</b> <b>2/22/62</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Jeanne C. Bateman, M. D.</b>			<b>22d. ADDRESS</b> <b>940 25th St., N.W., Washington 7, D.C.</b>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>2/24/62</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Ash Memorial.</b>	<b>23d. LOCATION (City, town or county) (State)</b> <b>Sandy Spring, Md.</b>		
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert L. Snowden</b>			<b>25a. REC'D BY REGISTRAR</b> <b>FEB 28 '62</b>	<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Thomas</b>	

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MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02317

## CERTIFICATE OF DEATH

02299

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burr's - Adelphi</u>		c. LENGTH OF STAY IN lb <u>1 yr. 2 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Point Branch Nursing Home</u>				d. STREET ADDRESS <u>4048 7th St. N.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ethel</u>		First <u>Ethel</u> Middle <u>Vella</u> Last <u>Tompkins</u>		4. DATE OF DEATH <u>Feb. 15</u>		Year <u>1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 23, 1882</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel S. Roberts</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Roberts</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Nursing home records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Same type terminal pneumonia of</u> DUE TO (b) <u>hypertensive heart disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, }		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1942</u> to <u>15 Feb</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>15 Feb</u> , 19 <u>62</u> , and that death occurred on <u>15 Feb</u> , 19 <u>62</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas E. Mattingly, M.D.</u>				22b. DATE SIGNED <u>15 Feb-62</u>		22c. PHYSICIAN'S NAME (Print) <u>Thomas E. Mattingly, M.D. 2200 R.I. Ave N.E. 18006</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-19-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Baptist Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Bethesda Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Deaf Funeral Home 4812 Duane Rd</u>				25a. REC'D BY REGISTRAR <u>FEB 19 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Charles A. Thomas</u>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02318

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02300

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY in 1b 2 days	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greenbelt		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's Hospital			d. STREET ADDRESS 7 K Southway Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Agnes Tillie Tonker			4. DATE OF DEATH Month Day Year February 6 19 62		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 2, 1908 54 yrs.		9. AGE (In years last birthday) Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Government Clerical		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Fred Richter		
14. MOTHER'S MAIDEN NAME Anna Cunat			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		
16. SOCIAL SECURITY NO. 579-07-2871			17. INFORMANT Mrs. Nancy M. Fox, 44B Ridge Road, Address Greenbelt, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO (b) Massive retroperitoneal hemorrhage DUE TO (c) Fracture of the pelvis, fractures of ribs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Passenger in an automobile that was in a collision 20c. TIME OF INJURY Month, Day, Year 2:30 p.m. 2/4/62 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road 20f. (City or town) (County) (State) Mitchellville P.G. Md					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED February 7, 1962 Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 10, 1962		22c. NAME OF CEMETERY Fort Lincoln Cemetery	
22d. LOCATION (City, town, or country) (State) Bladensburg, Maryland.		23. FUNERAL DIRECTOR ADDRESS W. W. CHAMBERS CO. Riverdale, Md.			
24a. REC'D BY REGISTRAR DATE FEB 9 '62		24b. REGISTRAR'S SIGNATURE Charles S. Thomas			

MEDICAL CERTIFICATION

FOR STATE  
HEALTH DEPT.



00318

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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James J. Price

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02319

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02301

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY in 1b <b>8 1/2 hrs.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				e. STREET ADDRESS <b>47 Mt. Rainier</b>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Edward</b> Last <b>Trainor</b>				4. DATE OF DEATH Month <b>February</b> Day <b>10</b> Year <b>1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Month <b>August</b> Day <b>1</b> Year <b>1909</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Alexander Trainor</b>				14. MOTHER'S MAIDEN NAME <b>Helen Elizabeth England</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>578-01-9160</b>			
17. INFORMANT <b>Joseph L. Trainor</b>				18. CAUSE OF DEATH (Enter only one cause pertinent for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> DUE TO (b) <b>331x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
21. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				22. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				24. (City or town) (County) (State)			
25. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				26. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
27. ACTUAL SIGNATURE <b>James I. Boyd</b> M.D.				28. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
29. EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>				30. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
31. ADDRESS (Street, city, town, or county)				32. DATE SIGNED <b>2/10/62</b>			
33. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				34. DATE THEREOF <b>2-12-62</b>			
35. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>				36. LOCATION (City, town, or country) (State) <b>Prince George's Co. Maryland</b>			
37. FUNERAL DIRECTOR <b>Raymond C. Ziska</b>				38. ADDRESS <b>8434 Georgia Ave. Silver Spring, Md.</b>			
39. REC'D BY REGISTRAR <b>FEB 14 '62</b>				40. REGISTRAR'S SIGNATURE <b>Arthur S. Thrane</b>			

02301

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02320

## CERTIFICATE OF DEATH

02302

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>39 Rogers Heights</b> d. STREET ADDRESS <b>5603 Decatur Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Arthur</b> <b>Emil</b> <b>Trost Jr.</b>		<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>6</b> Year <b>19 62</b>					
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>4-4-03</b>	<b>9. AGE</b> (In years last birthday) <b>58</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>2</b> Days <b>3</b> Hours <b>6</b> Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Ceramic</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Supplies</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Ohio</b>			
<b>13. FATHER'S NAME</b> <b>Arthur Emil Trost Sr.</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Lida Camp</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Josephine M. Trost same as #2 (Wife)</b> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary infarction</b> DUE TO (b) <b>Hypertensive cardiac-renal disease</b> DUE TO (c) <b>Urinary infection</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2-3-62</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>096-9</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>2-3-</b> <b>1962</b> , <b>to</b> <b>2-6-</b> <b>1962</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>2-6-</b> <b>1962</b> , <b>and that death occurred at</b> <b>11:30</b> <b>A.M.</b> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Dr. George J. Hageage</b>		<b>22b. DATE</b> <b>SIGNED</b>		<b>22c. PHYSICIAN'S NAME</b> (Type or print) <b>Dr. George J. Hageage</b>			
<b>22d. ADDRESS</b> <b>3717 38th Avenue, Cottage City, Maryland</b>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>2/10/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Olivet</b>			
<b>23d. LOCATION</b> (City, town or county) <b>Washington D. C.</b>		<b>(State)</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Francis Gasch's Sons</b>		<b>ADDRESS</b> <b>Hyattsville, Maryland</b>		<b>25a. REC'D BY REGISTRAR</b> <b>FEB 8 '62</b>			
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles E. Hanna</b>							

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02321

CERTIFICATE OF DEATH

Reg. Dist. No. 02303

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY P.G.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 05 Mitchellville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ENTERPRISE Rd		d. STREET ADDRESS ENTERPRISE Rd.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EVA Middle Jane Last Waesche		4. DATE OF DEATH Month 2 Day 18 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 26 1879
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Mitchellville Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward S WALKER		14. MOTHER'S MAIDEN NAME Sophronia Duckett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 215-36-5425	
17. INFORMANT Address Sophronia W Hunt (Daughter)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute intestinal obstruction 4:50 PM DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) mesenteric artery thrombosis (c) generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 9 days 9 days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Aortic Aneurysm, Arteriosclerotic heart disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1957 to Feb 18 1962, that I last saw the deceased alive on 2/17/62, 1962, and that death occurred at 4:30 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE James Kurtz		ADDRESS (Street, city or town, state) RFD Glenn Dale Md. DATE SIGNED 2/18/62	
PHYSICIAN'S NAME (Type) H. James Kurtz			
22a. BURIAL, CREMATION, REMOVAL (Specify) 2-20-62		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. M. Lee & Sons		ADDRESS 300 H St NE	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE FEB 21 '62			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
02322  
CERTIFICATE OF DEATH  
02304

1. PLACE OF DEATH a. COUNTY <b>Pr. Geo.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> c. LENGTH OF STAY IN 1b <b>2 Yrs.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Pr. Geo.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> 60	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>5707 Jamestown Rd.</b>		d. STREET ADDRESS <b>5707 Jamestown Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HERBERT</b> First <b>R.</b> Middle <b>WELLS</b> Last		4. DATE OF DEATH <b>Feb.</b> Month <b>9</b> Day <b>1962</b> Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>14 Mar 1896</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cartographic Aid, Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Army Map Serv.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James A. Wells</b>		14. MOTHER'S MAIDEN NAME <b>Linda Rodamor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW 1</b>		16. SOCIAL SECURITY NO. <b>172014639</b>	
17. INFORMANT <b>Adelaide W. Wells</b> Address <b>Same as # 2 (Wife)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Lymphatic Leukemia</b> 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>with Thrombocytopenia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchiectasis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 months</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-19</b> 19 <b>61</b> to <b>2-9</b> 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>2-9</b> 19 <b>62</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Ronald S. Fleischer M.D.</b>		22b. DATE SIGNED <b>2-9-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>RONALD S. FLEISCHER</b>		22d. ADDRESS <b>905 SHERIDAN ST. HYATTSVILLE, MD</b>	
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/12/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arl. Natl. Ceme.</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 13 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>			

02341

CERTIFICATE OF DEATH

02322

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1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

02323

MEDICAL CERTIFICATION

VR A15 (4)  
15M 7/61

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MD - MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02324

02306

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>10 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Laurel</b> d. STREET ADDRESS <b>1704 Sandy Springs Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James E. Whaley</b>		4. DATE OF DEATH <b>Feb 26 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 July 1903</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Insurance Agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Whitestone Va.</b>
13. FATHER'S NAME <b>Robert Kent Whaley Sr</b>		14. MOTHER'S MAIDEN NAME <b>Clara Belle Sanders</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <b>R.I. Whaley Jr., Whitestone Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>L'Aenrec's Cinnhosis of LIVER</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>S81.1</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/17/62</b> , 19 <b>62</b> , to <b>2/26/62</b> , that (I) (we) last saw the deceased alive on <b>2/26</b> , 19 <b>62</b> , and that death occurred at <b>9:40</b> P.M., from the causes and on the date stated above.			
22a. SIGNATURE <b>Norman Donat Comeau</b> M.D.		22b. DATE SIGNED <b>2/26/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>NORMAN DONAT COMEAU</b>		22d. ADDRESS <b>3503 Pennys Mt Rd Laurel Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/1/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Burtonsville Md</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>DeWitt Sanderson</b>		25. REC'D BY REGISTRAR <b>Arthur L. Kline</b>	
ADDRESS <b>Laurel Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

VR A15 (4)  
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02325											
02307											
Item 9 Film G308 3/6/62 mh											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 27 D.C.					
c. LENGTH OF STAY IN lb 8 days						d. STREET ADDRESS 6250 Rollins Ave. S.E.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Agnes						4. DATE OF DEATH Feb 25 19 62					
5. SEX Female						6. COLOR OR RACE Black					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH 22 May 1992					
9. AGE (In years, last birthday) 70 69 yrs.						10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None					
11. BIRTHPLACE (County & State, or foreign country) U.S.A.						12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Daniel Queen						14. MOTHER'S MAIDEN NAME Martha Snowden					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None						16. SOCIAL SECURITY NO. 50hn H. White - same as no. 2					
17. INFORMANT Address						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of stomach. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 2-17, 1962 to 2-25, 1962, that (I) (we) last saw the deceased alive on 2-25, 1962, and that death occurred at 6:45 A.M. from the causes end on the date stated above.											
22a. SIGNATURE Jeanne C Bateman M.D.						22b. DATE SIGNED 2/25/62					
22c. PHYSICIAN'S NAME (Type) Dr. Jeanne C Bateman M.D.						22d. ADDRESS 440-25th NW Wash DC					
23a. BURIAL, CREMATION, REMOVAL (Specify) 3/1/62						23b. DATE THEREOF					
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.						23d. LOCATION (City, town or county) (State) Wash. D.C.					
24 FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington						25a. REC'D BY REGISTRAR DATE MAR 1 '62					
25b. REGISTRAR'S SIGNATURE											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
02326 CERTIFICATE OF DEATH 02308										
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY -					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)					c. LENGTH OF STAY IN 1b 23 days					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3					
d. STREET ADDRESS 1330 S. Cap. St., S.E.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Charles W. White					4. DATE OF DEATH Month Day Year 2 3 1962					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/17/04		9. AGE (In years last birthday) 57 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck-driver		10b. KIND OF BUSINESS OR INDUSTRY Square Deal Truck Co.		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days - -		
13. FATHER'S NAME Dan Lewis					14. MOTHER'S MAIDEN NAME Eliza White Hawkins					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No -		16. SOCIAL SECURITY NO. 579-01-3073		17. INFORMANT Decedent Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive hemorrhage 581-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ruptured esophageal varices (c) Laennec's cirrhosis of the liver PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis; renal disease with azotemia, etiology undetermined; pulmonary edema										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1/11/60 to 2/3/62, that (I) (we) last saw the deceased alive on 2/3/62, and that death occurred at 3:20 A.M. from the causes and on the date stated above.										
22a. SIGNATURE Moe Weiss					22b. DATE SIGNED 2/3/62					
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.					22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-9-62		23c. NAME OF CEMETERY OR CREMATORY National Harmony Cemetery		23d. LOCATION (City, town or county) (State) Prince George's County, Md.				
24. FUNERAL DIRECTOR'S SIGNATURE John T. Rhiney & Co. Robert L. Plummer					ADDRESS 3015-12th N.E. D.C.		25a. REC'D BY REGISTRAR DATE FEB 8 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 02327 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02309

**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				e. STREET ADDRESS <b>407 69th. Place</b>			
3. NAME OF DECEASED (Type or print) <b>George</b> <b>Sidney</b> <b>Windsor</b>				f. DATE OF DEATH <b>February 21, 1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 4, 1916</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wash. Terminal</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Sidney John Windsor</b>				14. MOTHER'S MAIDEN NAME <b>May Estelle Windsor</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>719-03-1620</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertensive heart disease</b> (c) <b>Hypertensive heart disease</b> DUE TO cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>2/22/62</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/26/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		22d. LOCATION (City, town, or country) (State) <b>Colmar Manor, Maryland</b>	
23. FUNERAL DIRECTOR ADDRESS <b>Francis Gasch's Sons Hyattsville, Maryland</b>				24a. REC'D BY REGISTRAR <b>FEB 26 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	



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Prince George's  
Cheverly  
Prince George's General Hospital  
George  
X  
Male  
White  
Car Inspector  
Wash. Terminal  
Maryland  
U.S.A.

Sidney John Windsor  
Max Estelle Windsor  
719-07-1620 Jacob Herman Windsor 517 69th Place  
West Pleasant, Md.  
No

Transatlantic Travel Agency  
London  
X

James I. Boyd, M.D.  
F. Lincoln  
Columbus, Maryland  
2/22/62

Francis Gach's Sons  
Fayetteville, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div>1</div> <div>02328</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>02310</div>											
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>9 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>19 Morningside</b>				d. STREET ADDRESS <b>420 Allies Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>											
3. NAME OF DECEASED (Type or print) <b>Preston L Wide</b>			4. DATE OF DEATH <b>Feb 20 19 62</b>			a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>14 Jan 1905</b>		9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>LIFE INS</b>				11. BIRTHPLACE (County & State, or foreign country) <b>HEVENER OKLAHOMA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>UNKNOWN</b>						14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>350-01-5065</b>				17. INFORMANT <b>MRS IRENE WISE WASH 23 DC</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Hepatic Failure</b> 581.1 DUE TO <b>Laennec's Cirrhosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>10 yrs</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Congestive Failure &amp; A.S.H.D.</b>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (II) (this hospital) attended the deceased from <b>2/10/62</b> to <b>2/20/62</b> that (I) (we) last saw the deceased alive on <b>2/18/62</b> and that death occurred at <b>2:45AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Kevin L. Minchin M.D.</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>2/20/62</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. K L Minchin., M.D.</b>						22d. ADDRESS <b>7200 Marlboro Pike., S.E. Washington 28., D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>FEB 23 1962</b>			23c. NAME OF CEMETERY OR CREMATORY <b>WASH NAT</b>			23d. LOCATION (City, town or county) (State) <b>SUITLAND MD</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co</b>						ADDRESS <b>517-11 1/2 SE WASH DC</b>			25a. REC'D BY REGISTRAR <b>DATE FEB 23 '62</b>		
									25b. REGISTRAR'S SIGNATURE <b>Carling S. House</b>		

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02329 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02311

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE North Carolina b. COUNTY Grandville	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mitchellville		c. LENGTH OF STAY IN 1b Transient	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1 Mile off Enterprise Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last KMM Lounza (Lorenzo) Yarbough		4. DATE OF DEATH Month Day Year February 21 19 62	
5. SEX Male	6. COLOR OF RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1916
9. AGE (In years last birthday) 45 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Yarbough		14. MOTHER'S MAIDEN NAME Louise Lawrence	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yes ?	
17. INFORMANT Hortense Yarbough		Cedar Cabins Box 272A Jessup Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO (b) Crushing injuries to the body- multiple- severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Run over by a bull dozer	
20c. TIME OF INJURY Month, Day, Year 10:45 AM 2/21 19 62	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Constuction area Mitchellville P. G. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED 2/21/62	
EXAMINER'S NAME (Type) James I. Boyd		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-25-62	
22c. NAME OF CEMETERY OR CREMATORY POKES CHAPEL CEM.		22d. LOCATION (City, town, or country) (State) CREEDMOR, N.C.	
23. FUNERAL DIRECTOR Charles G. Cooper		24a. REC'D BY REGISTRAR 26 FEB '62	
CHARLES G. COOPER-512 CARROLLTON AV.		24b. REGISTRAR'S SIGNATURE	

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